



SUFFOLK HEALTHY AGEING NEEDS ASSESSMENT

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Consultant Lead:

Dr Jeptepkeny Ronoh

Authors:

Nowreen Azim, Health and Care Programme Manager

Dr Jeptepkeny Ronoh, Consultant in Public Health Medicine

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1. INTRODUCTION AND BACKGROUND

This report presents the findings from the Suffolk healthy ageing needs assessment. It brings together information and evidence on ageing and older people in Suffolk. It also highlights inequalities affecting Suffolk residents as they age and identifies gaps in local services relevant to older people.

The needs assessment was undertaken with the support of the healthy ageing needs assessment steering group. The group was made up of stakeholders from various organisations across the Suffolk system (please see “Acknowledgements” section for list of members).

Healthy ageing is a broad topic and there have been several attempts to define this. It was therefore imperative to agree the scope and definition for the purposes of this needs assessment. The Healthy Ageing Needs Assessment Steering Group agreed a definition based on work done by the European Commission because of the positive language used and the desire amongst stakeholders to create a positive narrative on ageing. The definition and scope are described next.

Definition and scope of healthy ageing

Healthy ageing is a concept that considers the ability of people of all ages to live a healthy, safe, and socially inclusive lifestyle. It has been defined as *“... the process of optimising opportunities for physical, social and mental health to enable older people to take an active part in society without discrimination and to enjoy an independent and good quality of life.”*¹

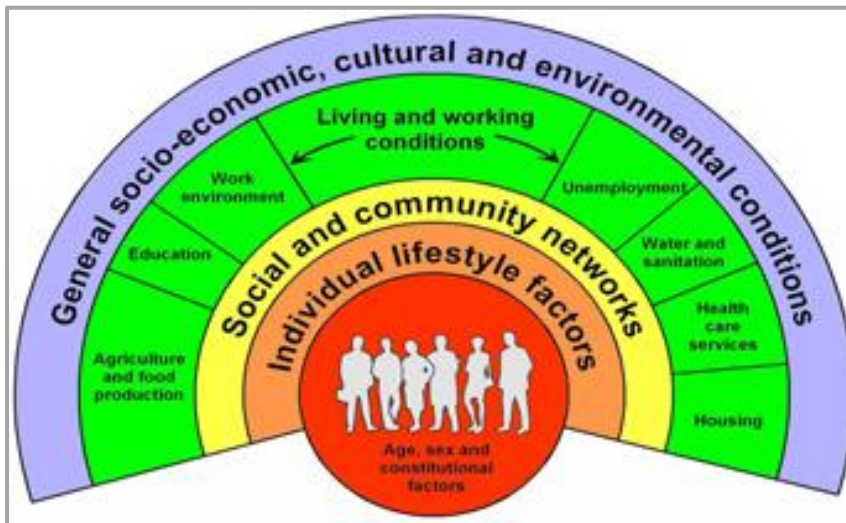
People age differently and *“there is no typical older person”*. Whilst ageing generally results in a gradual decline in physiological reserve, the degree of functional decline and subsequent loss of independence will depend on an individual’s level of fitness. An individual starting off from a lower level of fitness is more likely to tip into dependency when faced by minor stressors. Ensuring people remain as healthy and as fit as possible into old age is thus extremely vital. It could potentially delay the onset of frailty and dependency, allowing older people to work and play an active role in their communities.

The needs and capabilities of older people will also vary depending on their life experiences and exposure to different factors. Many of these factors are modifiable, presenting an opportunity for intervention and prevention.

Healthy ageing can and should be a realistic goal for all Suffolk residents. We therefore need to challenge many of the stereotypes associated with ageing and adopt a life-course approach in promoting healthy ageing.

Given the wide range of factors influencing an individual’s health and subsequent ageing, the wider determinants of health model by Dahlgren and Whitehead, illustrated below (Figure 1), has been adopted as a framework to define the scope of this needs assessment and to structure the report.

Figure 1: The Wider Determinants of Health Framework-Dahlgren and Whitehead



Source: Economics and Social Research Council, <http://www.esrc.ac.uk/about-us/50-years-of-esrc/50-achievements/the-dahlgren-whitehead-rainbow/>

The factors which contribute to healthy ageing are clearly numerous and complex and this is reflected by the multiplicity of initiatives and services established to support older people in Suffolk. These are often quite fragmented suggesting the need for an overarching system-wide strategic healthy ageing programme. This needs assessment is therefore a crucial first step. It is anticipated that the findings will inform the development of a healthy ageing strategy for Suffolk.

2. AGE, SEX AND CONSTITUTIONAL FACTORS

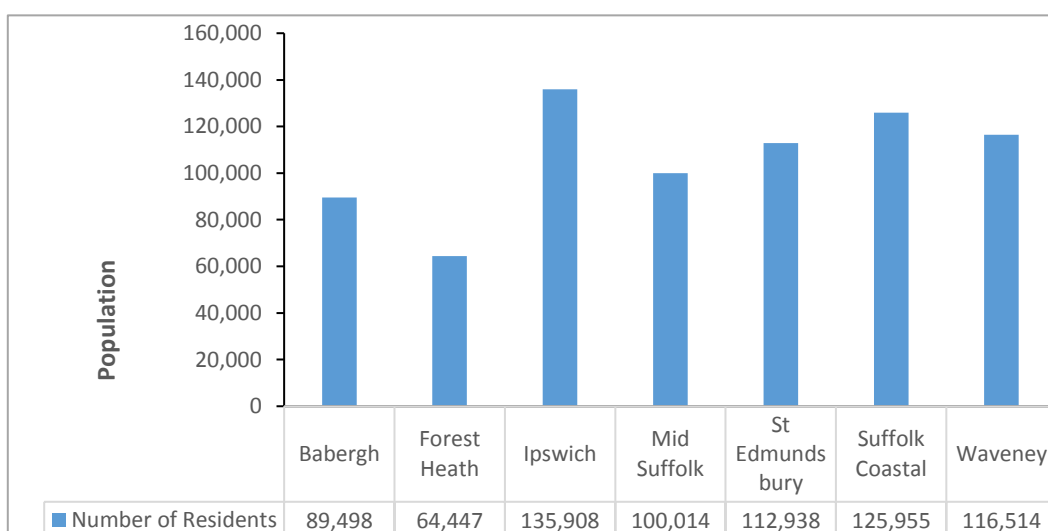
2.1 Population prevalence

To appreciate the need for a system wide healthy ageing programme, it is necessary to highlight Suffolk's demographic profile and the changes that are expected over the next few decades, especially amongst older people.

Suffolk is a large county covering approximately 1,466 square miles. It has seven district/boroughs, including Babergh, Forest Heath, Ipswich, Mid Suffolk, St Edmundsbury, Suffolk Coastal and Waveney and three Clinical Commissioning Groups (CCGs), including Ipswich and East Suffolk CCG (IESCCG), West Suffolk CCG (WSCCG), and part of Great Yarmouth and Waveney CCG (GYWCCG). The WSCCG and IESCCG geographies are part of the Suffolk and North East Essex Sustainability and Transformation Partnership (STP) or Integrated Care System (ICS) which covers a population of about 1 million. The Waveney area of Suffolk (part of GYWCCG) is part of the Norfolk and Waveney STP/ICS which also covers a population of about 1 million. It is worth noting that health and care partners in Suffolk have come together to form the Ipswich and East Suffolk Alliance and the West Suffolk Alliance to deliver integrated care. The alliances boundaries align to the IESCCG and WSCCG boundaries respectively.

The Office for National Statistics (ONS) provides population estimates and projections. According to ONS latest figures (mid-2016), the resident population of Suffolk was close to 745,300. There is a higher over 65 female population in Suffolk (54%) compared to a male population (46%). The (all age) population breakdown per local authority is shown in Figure 2. Within Suffolk, Ipswich has the highest population at 18.2% (just over 135,900) and Forest Health has the lowest population at 8.6% (about 64,500).²

Figure 2: All age population by Local Authority in Suffolk



Source: ONS Mid 2016 Population Estimates, Public Health Suffolk Analysis.

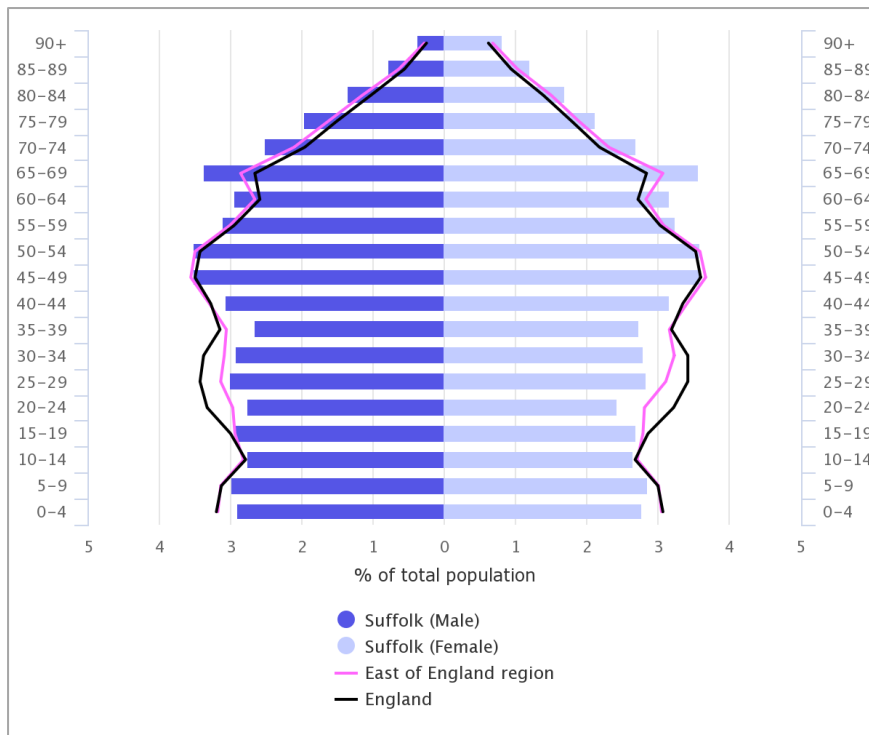
***These estimates are subject to change and were correct at the time this report was written.*

2.1.1 Population prevalence by age, district/borough and ethnicity

Population prevalence by age

The population pyramid below (Figure 3) highlights the significantly higher older population in Suffolk compared to England. Children and young people aged 0-19 make up about 22% of the population in Suffolk, adults aged 20-64 nearly 55%, and adults aged 65 and over make up nearly 23% (close to 169,800). Over 3% (approx. 24,000) of Suffolk's residents are aged 85 and over.³

Figure 3: Suffolk's all age population pyramid, 2016

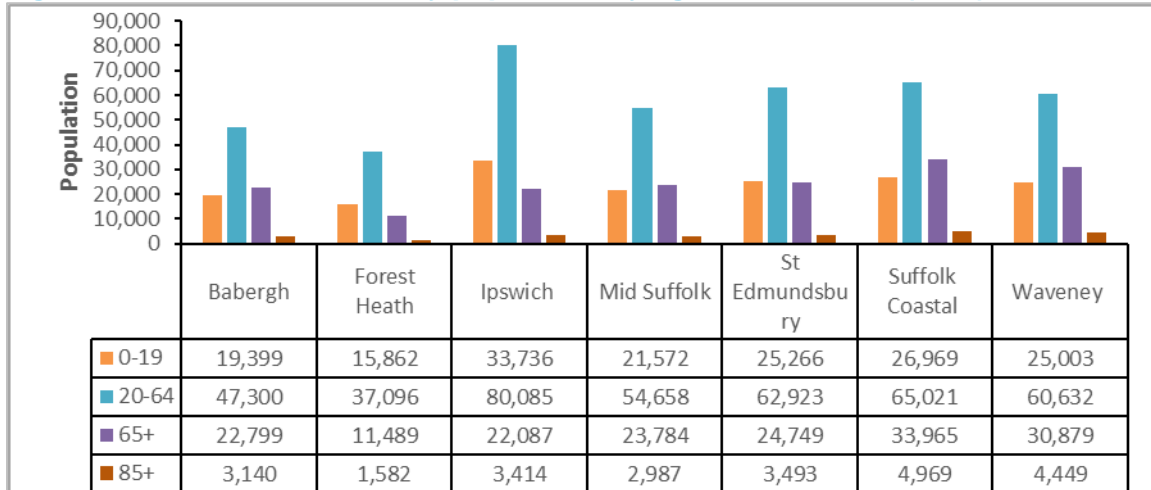


Source: Public Health England Fingertips

Population prevalence by district and borough

The age specific population breakdown by district and borough is shown in Figure 4. Suffolk Coastal has the highest proportion of people aged 65 and over (close to 34,000) and Forest Heath has the lowest (approximately 11,500). The population distribution is similar for the oldest age group aged 85 and over.

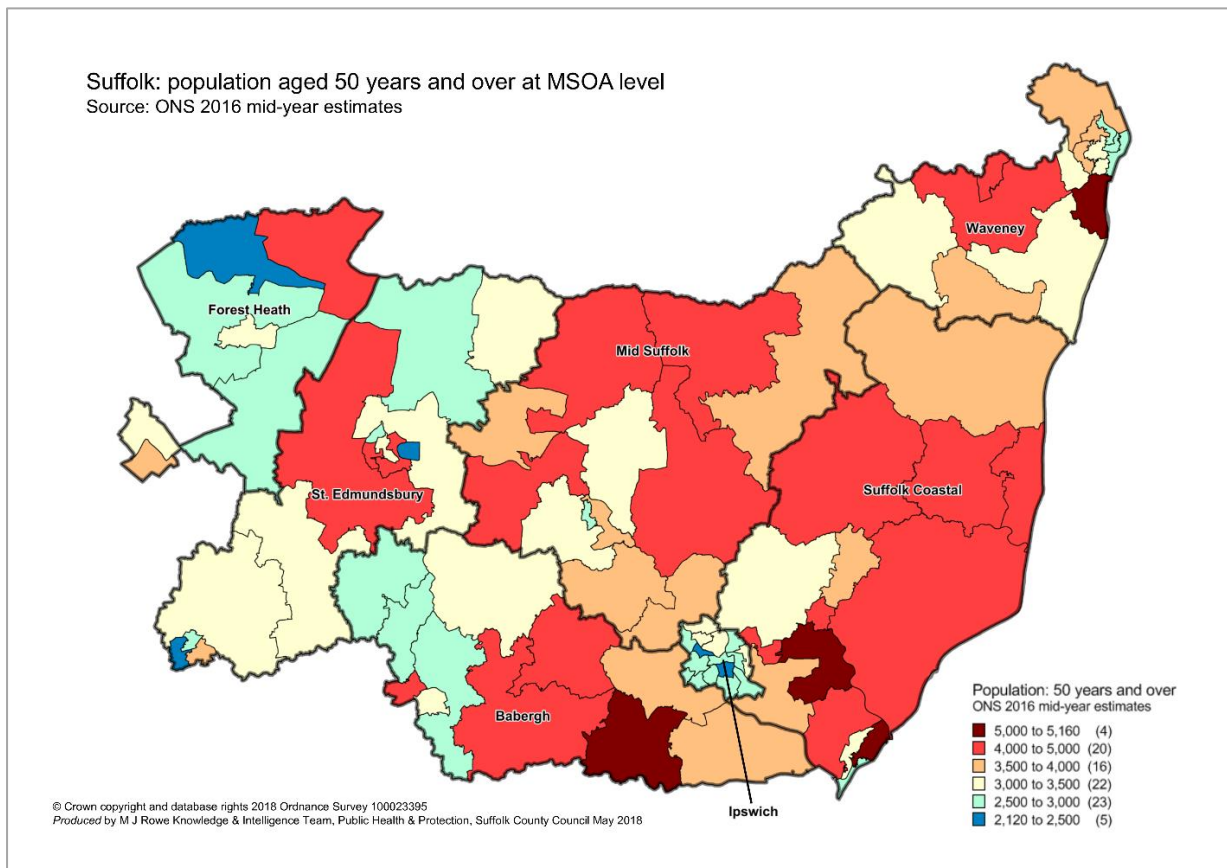
Figure 4: Suffolk local authority population by age bands. 2016 –(ONS)



Source: ONS Mid 2016 population estimates

According to ONS 2016 mid-year estimates (Figure 5), the distribution of over 50-year olds in Suffolk shows no clear pattern. With the exception of Ipswich, every local authority (LA) in the county has areas with high numbers of over 50-year olds. However, Mid Suffolk and Suffolk Coastal in general have higher numbers compared to the rest of the county. An estimated 42% of Suffolk's population aged over 50 live in rural areas and 58% in urban areas. This is consistent when analysed by sex and by sub age band.⁴

Figure 5: Distribution of Over 50's in Suffolk, 2016



Source: Knowledge and Intelligence Team, Public Health Suffolk, Suffolk County Council, 2018

Population prevalence by ethnicity

Ethnicity data for Suffolk is based on the 2011 Census which is due to be renewed in 2021. It is therefore likely that these ethnic demographics have changed over the last few years. According to 2011 Census, Suffolk's residents are predominately from a White ethnic background (95.2%), with 4.8% of Suffolk's population classified as from Black and Minority Ethnic Groups (BME). Waveney has the highest proportion of people from a White ethnic group (97.7%) and Ipswich has the lowest proportion (88.9%). According to data from Public Health England (PHE), in Suffolk, 1.8% of the (all age) population identify themselves Asian/Asian British compared to the national average of 7.8%. Broken down by CCG this is 1.6% of WSCCG, 2.2% of IESCCG and 1% of GYWCCG population.

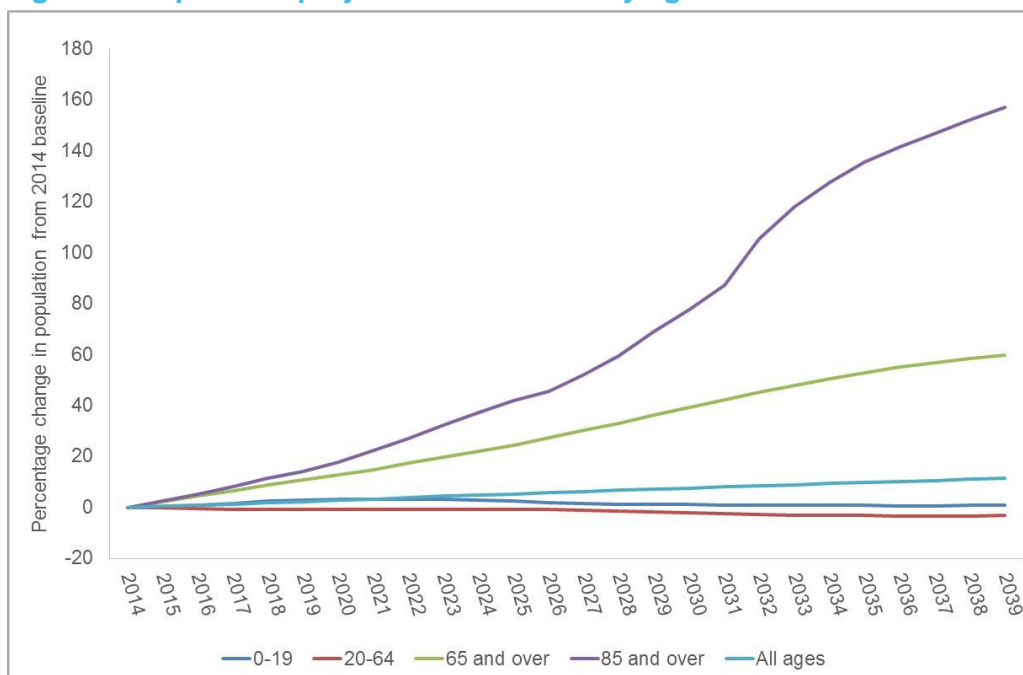
The ethnic demography for **older people** aged 65 and over in Suffolk is similar to that of the all-age population. About 99.3 % of those aged 65 and over are from a White ethnic background. However, for Ipswich this is lower, at 96.6%.

2.2. Population projections by age, district/borough and gender:

According to ONS estimates, it is expected that the all age population of Suffolk will grow from a 2014 baseline by 2.8% (from 738,500 to 759,400) in 2020, by 7.6% (794,600) in 2030 and by 11.4% (822,800) in 2039. However, the population change differs widely when different age groups are considered. While the population of those aged 65 and over is expected to increase by 59.7% between 2014 and 2039, it is anticipated that the highest increase (estimated at 156.8%) will be in the population aged 85 and over (Figure 6).

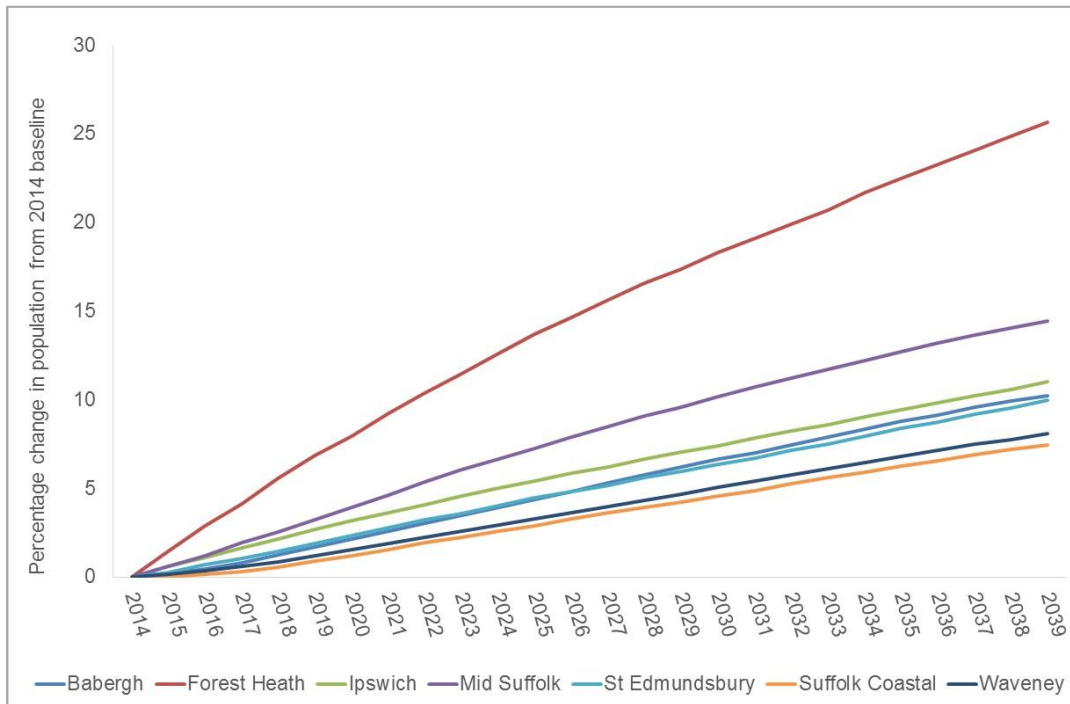
Analysis by Suffolk local authority areas shows that the all-age population is expected to change the most for Forest Heath, with an expected increase of 25.6% (from 62,800 to 78,900) between 2014 and 2039. Suffolk Coastal will see the least change, an increase of 7.5% (from 124,800 to 134,100), during this period (Figure 7).

Figure 6: Population projections in Suffolk by age band from 2014-2039



Source: ONS, 2014 population projections

Figure 7: Population projections by Suffolk local authority (LA) from 2014-2039

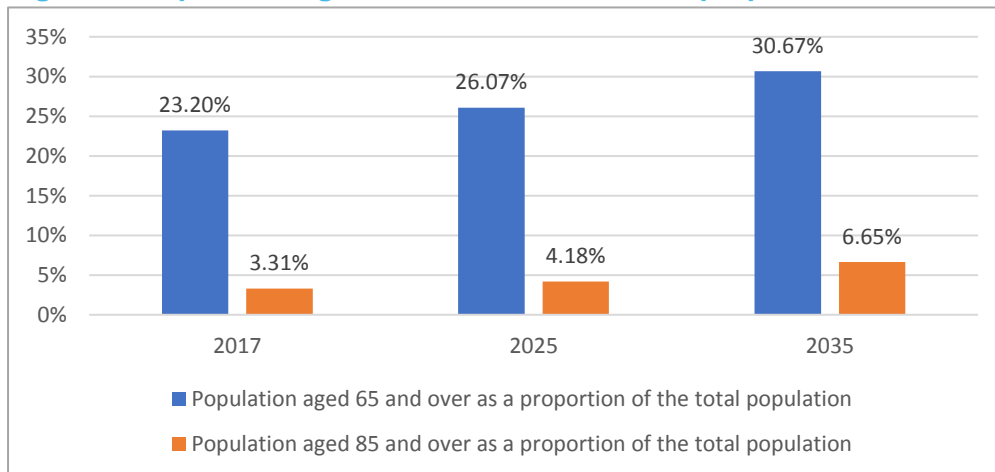


Source: ONS, 2014 population projections

2.2.1 Over 65's population projections

The online database, Projecting Older People Population Information (POPPI) is able to predict population size from 2017 to 2035 based on ONS figures.⁵ Suffolk in 2017 had approximately 23.2% of its population aged over 65, projected to rise to an estimated 30.6% (248,000) in 2035. The population aged over 85 is estimated to be around 3.3% of the total population and this is expected to double to almost 6.6% (~54,000) by 2035 (Figure 8).⁵ Further age and sex specific breakdown shows that whilst the proportion of 65-74-year olds in Suffolk are expected to decrease in both males and females from 2017 to 2035; the proportion of 75-84 and 85+ year olds are expected to increase for both sexes, however more so for females.

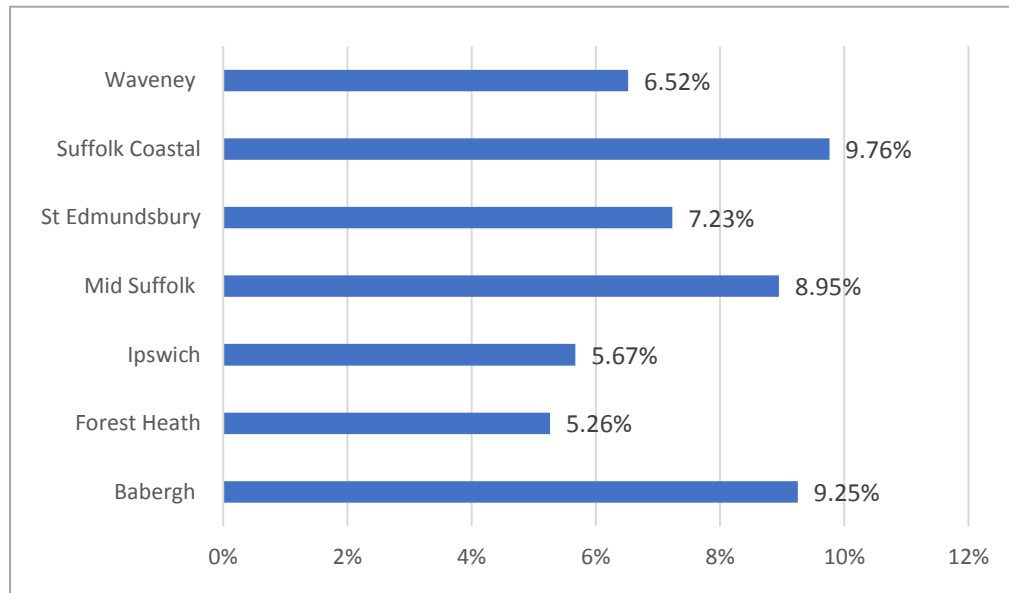
Figure 8: Population aged 65+/85+ in Suffolk as a proportion of the total population



Source: Projecting Older People Population Information (POPPI), 2017

Figure 9 below shows the percentage increase in the over 65 population (as a proportion of the total population) from 2017 to 2035 for Suffolk local authorities. Suffolk Coastal is expected to have the largest over 65 population increase of 9.8% (27.8% to 37.6%) followed by Babergh at 9.3% (26.3% to 35.5%). Forest Heath is expected to have the least over 65 population change at 5.3% (17.9% to 23.2%).

Figure 9: Percentage difference in the over 65 population by Suffolk LA, 2017-2035

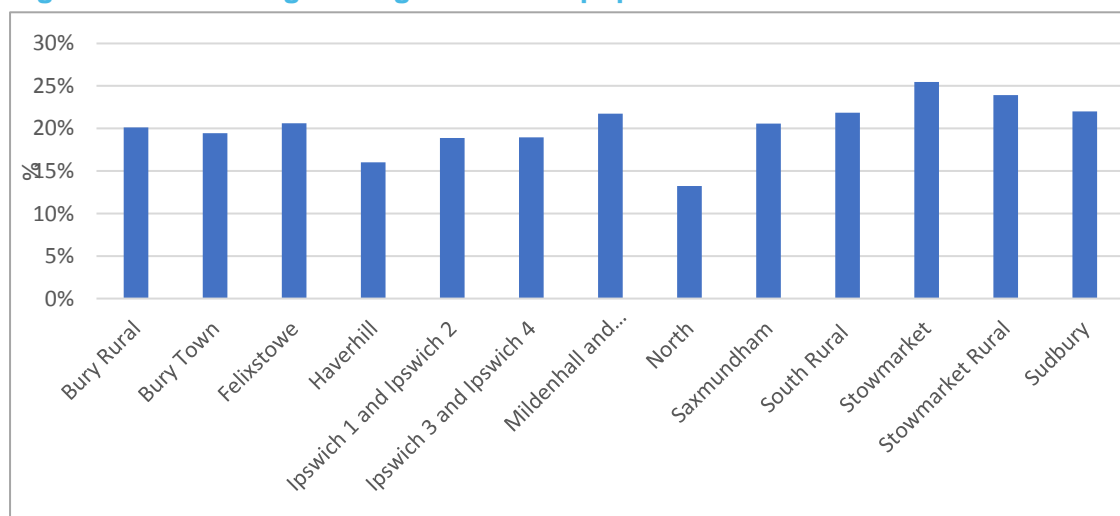


Source: Projecting Older People Population Information (POPPI), 2017

Population projections by Integrated Neighbourhood Team (INT) areas

There are 13 Connect Project (also called INT areas) in Suffolk. The percentage changes in the over 65 population from 2016 to 2025 are shown in Figure 10. The Stowmarket INT area is predicted to have the highest increase in the population aged over 65, with an increase of 25.5% from 2016 to 2025 while the North INT area is expected to have the smallest change (13.3%). It is however worth noting that the North INT currently has the highest number of over 65's compared to other INT areas.

Figure 10: Percentage change in the 65+ population from 2016 to 2025

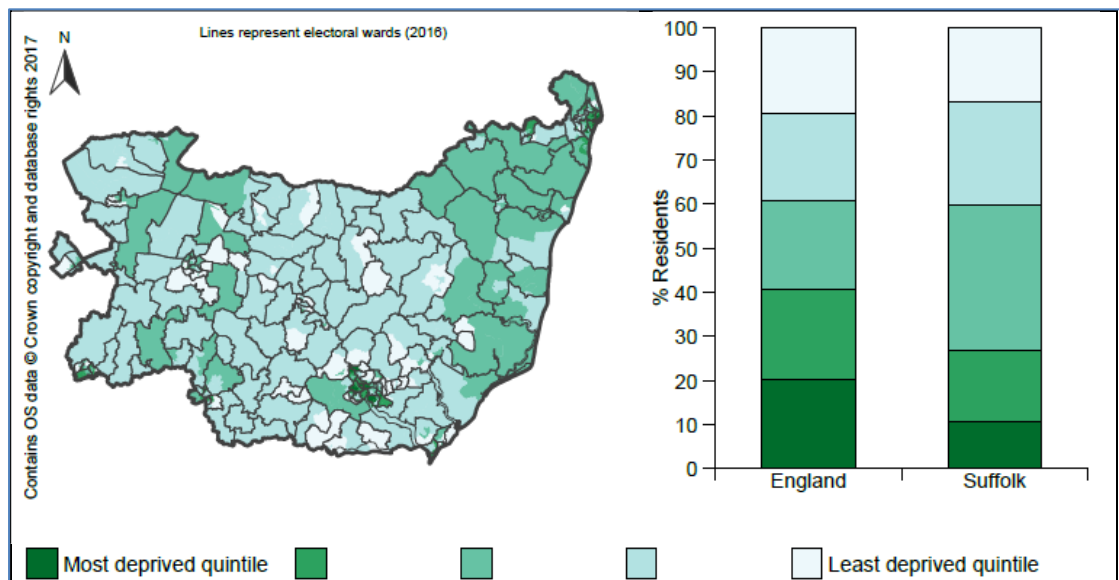


Source: Adult and Community Services (ACS) Analysis, 2018

2.3 Deprivation:

Suffolk is relatively affluent, according to the 2015 Index of Multiple Deprivation. There are however pockets of deprivation spread across the county. Around 11% of the county's residents live in lower super output areas (LSOAs) that are defined as the 20% *most* deprived in England.³ Ipswich has the highest proportion residents living in deprived areas, followed by Lowestoft and Felixstowe. Around 17% of Suffolk live in the 20% *least* deprived areas, compared to 19% in England. (Figure 11)

Figure 11: Index of Multiple Deprivation for Suffolk, 2015



Source: Public Health England

2.4 Life expectancy

2.4.1 Life expectancy at birth

According to the most recent available data (2014-2016), males and females in Suffolk can expect to live to 80.8 years and 84.2 years respectively. These are both higher than the England and East of England averages as shown in Table 1. Life expectancy has increased over the last decade. Whilst greater longevity is a success story, as outlined in the next section, many of these years are being spent in poor health or with disability.

2.4.2 Healthy life expectancy

There are two further measures, healthy life expectancy, and life expectancy at age 65, which provide more valuable information on the health of Suffolk's population. The current healthy life expectancy at birth (years spent in good health) for males in Suffolk is 63.6 years and in females this is 65.4 years. (Table 1) Male healthy life expectancy is now lower than the East of England average (64.7) but higher than the national average (63.3). The most recent data on the trends in healthy life expectancy show us that whilst there had been a steep gain since 2002 to 2009, there has been a loss of gains in the last few years (2009-2016), particularly for women (Figure 12).

Figure 12: Trend over time in Healthy Life Expectancy for Suffolk Males and Females



	Male	Confidence Interval	Value	Confidence Intervals
2009 - 11	65.3		68.1	
2010 - 12	66.1		68.0	
2011 - 13	64.5		66.2	
2012 - 14	65.8		66.1	
2013 - 15	65.1	(63.7- 66.5)	66.7	(65.2 - 68.2)
2014 - 16	63.6	(62.1- 65.0)	65.4	(63.7 - 67.1)

Source: Public Health England (Fingertips) and ONS

Male healthy life expectancy decreased by 1.5 years from 2013-2015 and 2014-2016. While female healthy life expectancy decreased by 1.3 years over the same period. It is however worth noting that this decrease was not statistically significant.

The Chartered Institute of Public Finance and Accountancy (CIPFA) have created a model which seeks to measure similarities between Local Authorities. Compared to its 15 other CIPFA statistical neighbours, Suffolk ranks in 7th place for female healthy life expectancy and 9th place for male healthy life expectancy, a ranking position Suffolk should aim to improve on in the coming years.

2.4.3 Life expectancy at age 65

Life expectancy at age 65 has increased from 2013-2015 to 2014-2016 in Suffolk. Suffolk males can expect a life expectancy of 19.7 years, at age 65 (0.2 years higher than the previous years) and females can expect a life expectancy at age 65, of 21.9 years (0.1 years higher than 2013-2015). It is important to note these are both higher than the averages for East of England (19.2 years and 21.5 years for males and females respectively) and England (18.8 years and 21.1 years for males and females respectively) (Table 1).

Table 1: Life expectancy table, 2014-2016

2014-2016	Suffolk		East of England		England	
	Male	Female	Male	Female	Male	Female
Life expectancy at birth	80.8	84.2	80.4	83.7	79.5	83.1
Life expectancy at age 65	19.7	21.9	19.2	21.5	18.8	21.1
Healthy life expectancy at birth	63.6	65.4	64.7	64.6	63.3	63.9

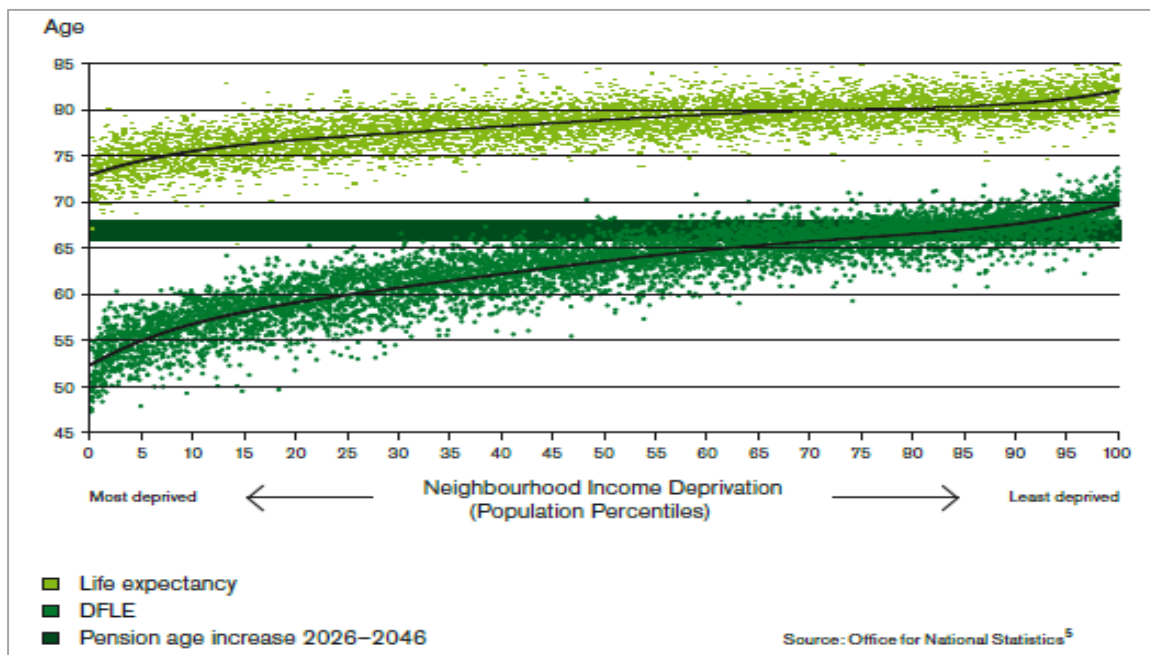
Source: ONS, 2017

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/datasets/healthstatelifeexpectancyallagesuk>

2.4.4 Inequalities in life expectancy

The 2010 Marmot Review on health inequalities showed that nationally, there was a significant difference in life expectancy between people living in poorer areas and those living in more affluent areas. The standout difference however was in disability-free or healthy life expectancy, which was on average estimated to be about 17 years less for those most deprived, compared to those least deprived. This is illustrated below in Figure 13. When compared to those living in the most affluent areas, people living in poorer areas on average live shorter lives and spend more of that time living in disability. The early onset of ill health and subsequent disability suggests they are less likely to remain independent and in work and therefore more likely to experience further economic disadvantage and suffer mental ill health.

Figure 13: Life expectancy/ disability-free life expectancy at birth by income level, 1999-2003



Source: 2010 Marmot Review on Health Inequalities

Public Health England's (PHE) indicator 'The Slope Index of Inequality' measures inequalities in life expectancy (at birth) within English local authorities and is based on deprivation deciles. The data in simple terms show that a boy and a girl born in the most deprived part of Suffolk will live on average 7.3 years and 4.3 years **less** than a boy and girl born in the least deprived part of Suffolk respectively. This further reiterates the need to take a life course approach in promoting healthy ageing, as deprivation has a significant impact on an individual's future and the disadvantage accrues over a life time.

Summary: Age Sex and Constitutional Factors

- ❖ There are currently 1 in 5 people over the age of 65 in Suffolk, this is expected to rise to 1 in 3 in 20 years' time.
- ❖ We have a significantly ageing population; some areas such as Suffolk Coastal and Babergh will see more marked increases (~10%) in the number of older people living there.
- ❖ Stowmarket INT is predicted to have the highest increase in population aged over 65 years between 2016 and 2025 while the North INT is expected to see the smallest increase.
- ❖ Life expectancy has increased over the last decade, however, there has been a fall in healthy life expectancy over the years. Many of these years are therefore being spent in poor health or with disability.
- ❖ Current healthy life expectancy is 63.6 years (males) and 65.4 years (females). This is lower than that of Suffolk's closest statistical neighbours.
- ❖ A boy and a girl born in the most deprived part of Suffolk will live on average 7.3 years and 4.3 years less than a boy and girl born in the least deprived part of Suffolk respectively.
- ❖ When compared to those living in the most affluent areas, people living in poorer areas on average live shorter lives and spend more of that time living in disability. Deprivation has a significant impact on an individual's future and the disadvantage accrues over a life time. The early onset of ill health and disability means they are less likely to remain independent and in work and therefore more likely to experience economic disadvantage and suffer mental ill health. It is therefore important to take a life course approach to healthy ageing.

3. INDIVIDUAL LIFESTYLE FACTORS

Case Study: Saska-63 years

The Great East Swim outreach programme is part of the Most Active County programme of interventions aimed at moving individuals from inactivity to taking part in regular physical activity. The programme looks to support individuals who are doing little or no exercise or suffering from a long term physical or mental health condition at the point of sign up. Participants complete a 12-week supported training programme to complete the challenge of an open water swim.

Saska is originally from Suffolk and later moved to Essex in 2003. She is self-employed and works part-time hours. Her interests and hobbies include riding a motorbike in the summer months, swimming three times a week, walking the dog and relaxing with a good book. Here is Saska's Healthy Ageing Story:

What does positive ageing mean to you?

"Fighting the mental tendency to give in to age. Keeping fit and appreciating that I can swim and walk and do everything I want to do – without medication"

What do you do to keep fit, strong and healthy?

"Swim, swim, swim, mainly because I can. I was lucky to get involved with Suffolk Sport sponsorship at Felixstowe in February 2015 and faced my hang up and learnt to swim for the Great East Swim. Recently I had lens replacement on my eyes so for the first time was able to see enough to swim and know who I was with and where I was going. I have loved the challenge and companionship of other folks swimming – mainly younger than me. Even when I don't feel like making the effort, when I do the positive mental effect and feel good factor is ACE!"

Describe your Great East Swim experience?

"I got involved and at first I was hopeless. Did the 12 sessions and with a struggle I managed the half mile. By then I knew how good it was for me so I continued and worked towards the mile in 2016. The day was scary but fun and a huge buzz from folks achieving their own personal goal."

How did you feel afterwards, and how do you believe this experience has affected your life?

"No doubt the opportunity opened up a more energetic approach to life. I think fit and fight age every day. I have also managed to encourage my 30-year-old son to swim. After years of drinking and smoking and he feels the benefit. We swim once a week and challenge each other to swim further and better."

3.1.1 Physical activity

The impact of physical activity (PA) on healthy ageing is quite widely known and understood. It is perhaps one of the most valuable ways that one can acquire multiple positive health benefits. The Global Burden of Disease study's most recent findings has labelled physical inactivity as one of the top ten causes of disease and disability within England.⁶

The level of PA an individual undertakes can be a strong predictor of healthy ageing. According to the Chief Medical Officers (CMO) guidelines, it is recommended that older adults do at least 150 minutes moderate intensity or 75 minutes vigorous intensity PA or a combination of both per week. However, with age the number of people undertaking PA declines. Nationally, only 1 in 10 males aged over 75 and 1 in 20 females aged over 75 meet the recommended guidelines for PA. Types of PA for older people that meet CMO guidelines are based on improving balance, reducing sedentary behaviour and strengthening muscles through activities such as aerobics, Tai Chi and regular walks in the garden. It has also been emphasised that older people with certain conditions may have difficulties in meeting these recommendations immediately, therefore focusing on gradual incremental increases in the duration and intensity of PA is the safest and most beneficial way to gain benefits in this cohort.⁶

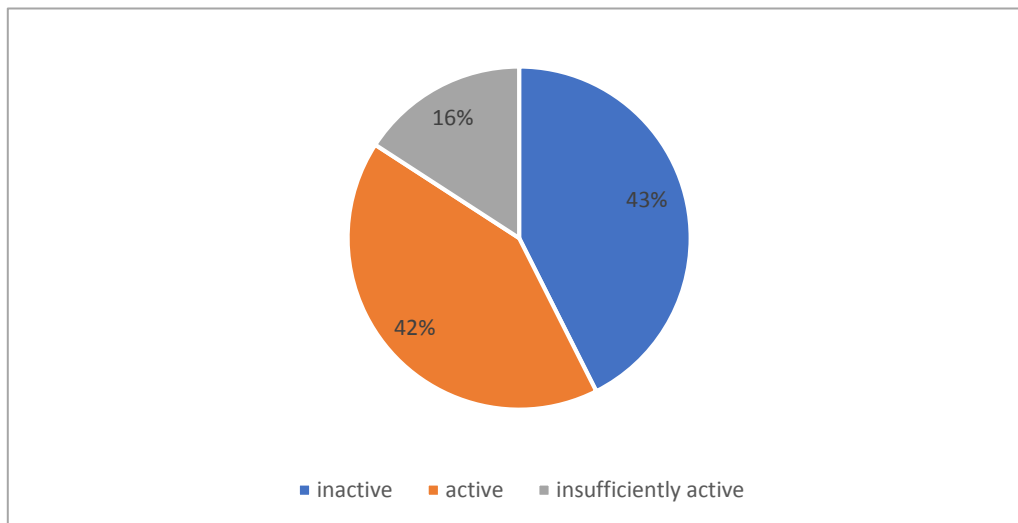
There are also certain inequalities in PA that exist within Suffolk. These have been reported in the recent [Suffolk Physical Activity Needs Assessment](#) available on the [Healthy Suffolk Website](#).⁶

- The proportion of men and women classified as physically active was 62.7% and 51.7% respectively.
- Only 35.1% of Suffolk residents with a limiting illness or disability achieve the recommended levels of PA compared to 61.5% of those without illness or disability.
- 23.4% of those grouped in the top 4 socioeconomic classes were classed as inactive whereas 31.7% of those in the latter 4 classes were identified as inactive, demonstrating a socio-economic gradient in PA levels.
- PA is significantly lower in the unemployed - 17.9 % of people in full-time employment are classified as inactive compared to 41.9% of those that are unemployed.

There is growing research to suggest that physical activity and associated interventions can result in better physical and mental health outcomes. Furthermore, there are studies which support the theory that improved availability of and access to greenspace can have beneficial impacts on long and short mental health outcomes, especially surrounding the use of exercise as a treatment for depression. Sport England recently identified that of the 43.7m total adult population in England, 18.2m who are not currently active outdoors want to re-engage in outdoor activity in the next 12 months.⁶

Public Health Suffolk conducted a Suffolk Adults Physical Activity Survey (SAPAS) completed by 1407 residents, which has informed the PA Needs Assessment.⁶ It must be noted that this was a self-reported survey. Analysis for the 65+ age group showed that 42.5% of respondents reported they were inactive, 41.4% reported active levels while 16.3% reported insufficiently active levels (Figure 14).⁶

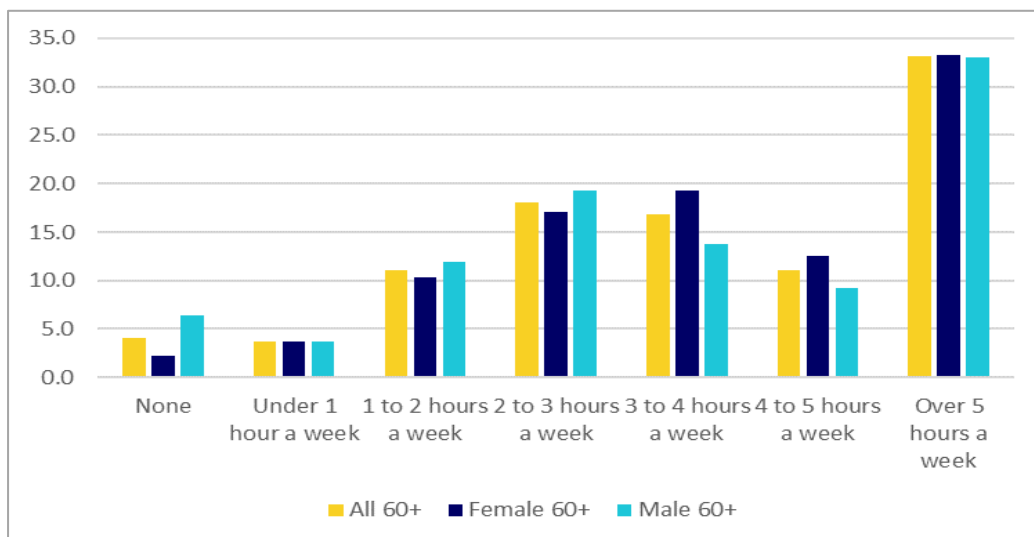
Figure 14: Activity level of people age 65+ in Suffolk



Source: Suffolk Adults Physical Activity Survey (SAPAS), 2017

Moderate and vigorous physical activity (MVPA) is defined as moderate activity that will raise heart rates, therefore making the individual breathe faster and feel warmer. In the survey, when asked about the number of hours of MVPA completed in a week, more males and females aged over 60 reported undertaking over 5 hrs of PA a week (~33%). Approximately 4% of all over 60's, reported <1hr PA a week, ~4.5% reported no PA at all, whilst the remaining 58.5% undertook between 1-2hrs and 4-5hrs/wk. This high number suggests possible over reporting or a lack of understanding of what MVPA entails. (Figure 15)

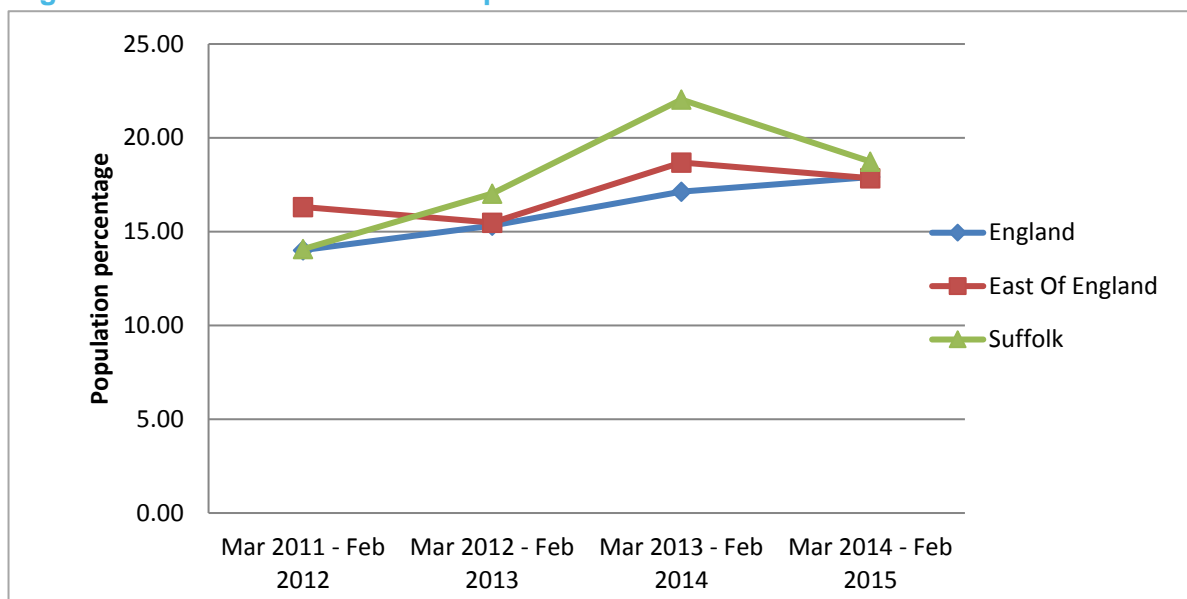
Figure 15: Number of hours of moderate to vigorous physical activity completed a week for over 60's



Source: Physical Activity Needs Assessment, Suffolk https://www.healthysuffolk.org.uk/uploads/2017-10-12_Needs_assessment_Final.pdf

Data from PHE looking at the trends over time for the public's utilisation of space for exercise or health reasons, shows that Suffolk usage is 18%, which is higher than the regional and national estimates. However, it is notable that this has reduced since 2014 (Figure 16).

Figure 16: Utilisation of outdoor space for exercise and health reasons



Source: Physical Activity Needs Assessment, Suffolk https://www.healthysuffolk.org.uk/uploads/2017-10-12_Needs_assessment_Final.pdf

It is estimated that within Suffolk, there are 244.6 premature deaths per 100,000 people (deaths in people aged under 75 years) per year attributed to physical inactivity. The cost of inactivity per year to Suffolk per 100,000 people is estimated to be £17,718,700.⁶ The table below (Table 2) shows rough estimates of the impact of differing levels of the recommended physical activity on death and ill health events in Suffolk. The estimates are based on how much physical activity reduces these events in individuals aged 40-79 years. Additionally, financial costs have been calculated using data from the National Programme Budget Project (NPBP) 2009/10 and applying population attributable fractions for each disease. This should be interpreted with caution as the data used in the calculations are slightly dated.⁶

An example of how to interpret the information in Table 2 below would be: Looking at *Emergency admissions for Coronary Heart Disease (CHD)*, out of the 1,436 events that occur in a year, 56 could be prevented if the Suffolk population aged 40-79 was '50% active' (compared to recommended levels). The financial cost of CHD emergency admissions attributable to physical inactivity is £7,602,313.

Table 2: Ill health events preventable at different levels of PA in the Suffolk population

Conditions preventable through physical activity	Number of events	If 100% active	If 75% active	If 50% active	If 25% active	Financial cost of inactivity
All deaths (persons aged 40-79 years)	2682	478	324	170	16	
Emergency admissions for coronary heart disease	1436	158	108	56	5	£7,602,313
Incident cases of breast cancer	468	95	64	34	3	£854,606
Incident cases of colorectal cancer	405	81	54	28	3	£1,085,154
Prevalent cases of diabetes	30789	4130	2797	1464	132	£2,620,533
Cerebrovascular disease (incl stroke)	1466	Data not available				£1,884,081

3.2 Diet and Nutrition

3.2.1 Obesity

Obesity is a major public health problem both nationally and within Suffolk. The UK has some of the highest adult obesity rates in western Europe, and as life expectancy is increasing, the prevalence of obesity is also rising steadily amongst older groups. Obesity is known to increase the risk of developing diabetes, cardiovascular diseases, and cancers. The World Health Organisation (WHO) had recently estimated 7 - 41% of certain cancers are attributable to obesity or being overweight.⁷

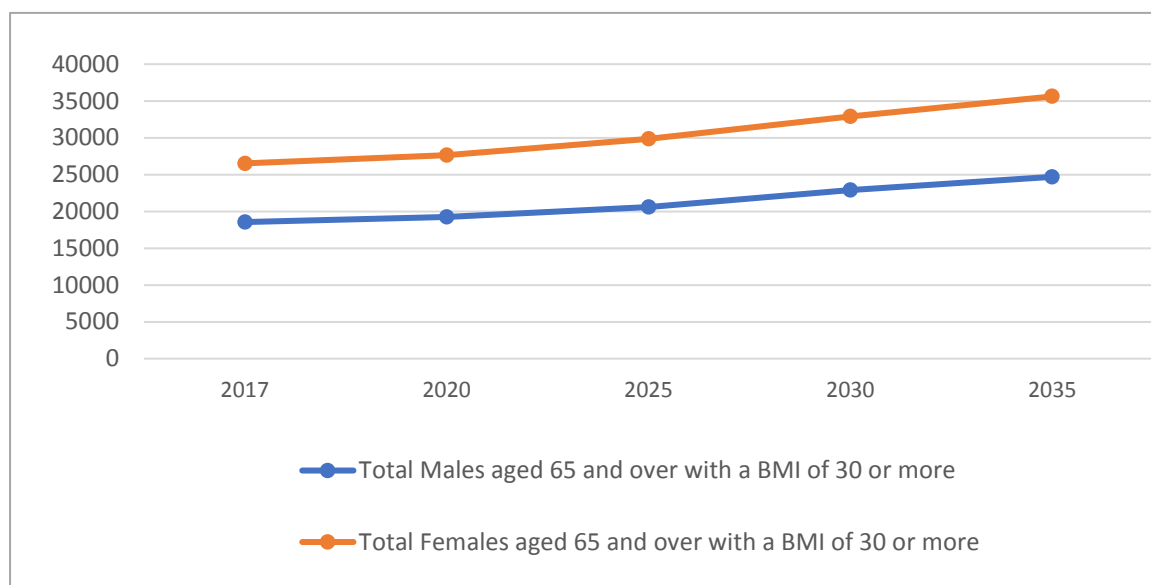
Obesity combined with the process of ageing leads to an increased risk of disease and death but also reduces the overall quality of life. Excess weight has been found to be associated with difficulties in people finding work, and can affect self-esteem and mental health.⁷

There are also national inequalities; there is variation in obesity prevalence amongst ethnic minority groups, as women from Black Caribbean and South Asian ethnicities are estimated to have higher obesity levels. Furthermore, it is estimated that being obese can reduce an individual's life expectancy by up to 10 years.⁸

POPPI has used findings from the Health Survey England 2005, to predict obesity prevalence in older people until 2035 using the measure of Body Mass Index (BMI). An individual with a BMI of 30 or more is considered 'obese', and with a BMI of 40 or more is considered 'morbidly obese'.

Within Suffolk, Figure 17 show females aged 65 and over predicted to have a BMI of 30 or over is expected to rise by 34% from 2017 to 2035, for males a very similar pattern (a 33% rise) is expected.

Figure 17: Total males/females aged 65 and over predicted with a BMI>30



Source: Projecting Older People Population Information (POPPI), 2017

Figure 18: Excess weight-persons 16+years 2013-15



Source: Sport England, Suffolk Observatory

Additionally, Figure 18 above shows that excess weight (BMI>25) for those aged 16+ years in Suffolk is higher than both the regional and national averages at 66.1%.

3.2.2 Diabetes

A study by Imperial College London, has found that an estimated 800,000 cancers worldwide could be attributable to the combination of having both diabetes and obesity.⁹ Six percent of these worldwide cancers (12 types) were caused by the impacts of having diabetes and a BMI of over 25. For males, liver cancer was the type of cancer most affected by the effects of diabetes and obesity, whilst for females this was breast cancer.

Data on diabetes prevalence in Suffolk is limited. According to PHE, in 2015/16 the estimated prevalence of (diagnosed and undiagnosed) diabetes in those aged 16 and over was 9.1%, which is higher than the England average of 8.5% (Figure 19).

Figure 19: Estimated prevalence of diabetes (aged 16+)

Compared with benchmark		Better	Similar	Worse	Lower	Similar	Higher	Not compared						
Indicator	Period	England	East of England region	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
Estimated prevalence of diabetes (undiagnosed and diagnosed)	2015/16	8.5	-	9.3	7.6	7.5	8.5	7.8	10.2	9.3	8.7	8.8	9.1	7.9

Source: Public Health England Profiles-Diabetes

The estimate for people aged 16 and over with diagnosed and undiagnosed diabetes in Suffolk in 2015/16 was 54,592 people. This is expected to rise to 71,268 people by 2035. This is clearly a considerable growth in the prevalence of diabetes, equating to about 30% in 20 years' time. It underlines the importance of current diabetes prevention initiatives.

3.2.3 Under-nutrition

Whilst obesity is a major problem for older people, on the other end of the spectrum a growing issue which affects many older people is under-nutrition. It is estimated that 1.3 million people aged over 65 in the UK are malnourished. According to the BAPEN nutrition surveys, up to a third of patients admitted to a hospital are at risk of malnutrition, this rises to 42% of patients admitted to care homes.¹⁰ As we age, our sense of taste and smell is subject to change, and this can affect appetite. Some older people as a result tend to eat less, and this coupled with the body being less able to absorb nutrients efficiently with age, means it may be harder for older people to get all the necessary nutrients for good health.¹¹




Another major factor that contributes to under-nutrition amongst older people is being unable to cook hot meals for themselves for a variety of reasons (e.g. immobility, health reasons, shop closures and a loss of community transport), which associates this problem strongly with isolation. According to a 2013 Age UK Survey, 11% of older people in the UK found it difficult to get to a corner shop and similarly to access their local supermarket.¹⁰

The All Parliamentary Group On Hunger, recently stated that "malnutrition in the elderly is set to cost the NHS and social care £15.7 billion a year by 2030".¹² They estimate that over a million older people are likely to be malnourished, and have recommended that better malnutrition data collection, screening tools, and targeted interventions that feed and care for older people could save the NHS millions.

Within the ongoing EPIC Study, it has been suggested that in the UK, following a Mediterranean diet which is typically rich in fruits, vegetables and nuts can lead to reduced mortality amongst healthy older people.¹³ The EPIC study has also shown that "a rise in the level of vitamin C equivalent to a 50g per day increase in fruit and vegetable consumption could cut the risk of dying early from any cause by 20 per cent".¹³ Although further research is needed to determine exact dietary associations, there is reliable evidence that ensuring a high intake of fruits and vegetables is beneficial.

Information on older people’s intake of fruits and vegetables in Suffolk is not available. However, the proportion of over 16’s in Suffolk meeting the recommended ‘5 a day’ is 57.4%, which is similar to both the regional and national averages (54.5% and 52.3%). The average number of portions of fruit consumed daily for adults is 2.62 portions, and average number of portions of vegetables consumed daily is 2.43 portions, both of which are just higher than national and regional averages. (Figure 20)

Figure 20: Average number of portions of fruit and vegetables consumed daily in Suffolk,

2.11i - Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)	2015	-	-	57.4%	54.5%	52.3%	36.5%		68.8%
2.11ii - Average number of portions of fruit consumed daily (adults)	2015	-	-	2.62	2.55	2.51	1.80		2.93
2.11iii - Average number of portions of vegetables consumed daily (adults)	2015	-	-	2.43	2.34	2.27	1.70		3.00

Source: Public Health England, Fingertips

3.3 Smoking

Smoking remains the main risk factor for a vast range of diseases and ill health, most notably cardiovascular and respiratory illnesses. Smoking also plays an important role in the development of other conditions that arise more commonly amongst older aged people, including dementia, diabetes, and skin problems. Therefore, smoking can impact not only one’s quantity of life but also the quality of life and is projected to become the main cause of death and disability worldwide by 2020 replacing heart disease and stroke.⁶

The latest data from Public Health England shows that as of 2017, smoking prevalence in Suffolk was 13.9% (in population aged 18 years plus) with more male smokers than females at 16.4% and 11.6% respectively. (Figure 21) This is statistically similar to England and other East of England counties. Suffolk has the 10th highest adult smoking prevalence when compared to its CIPFA statistical neighbours (15 other counties).

Figure 21: Adult smoking prevalence in Suffolk and East of England, 2017

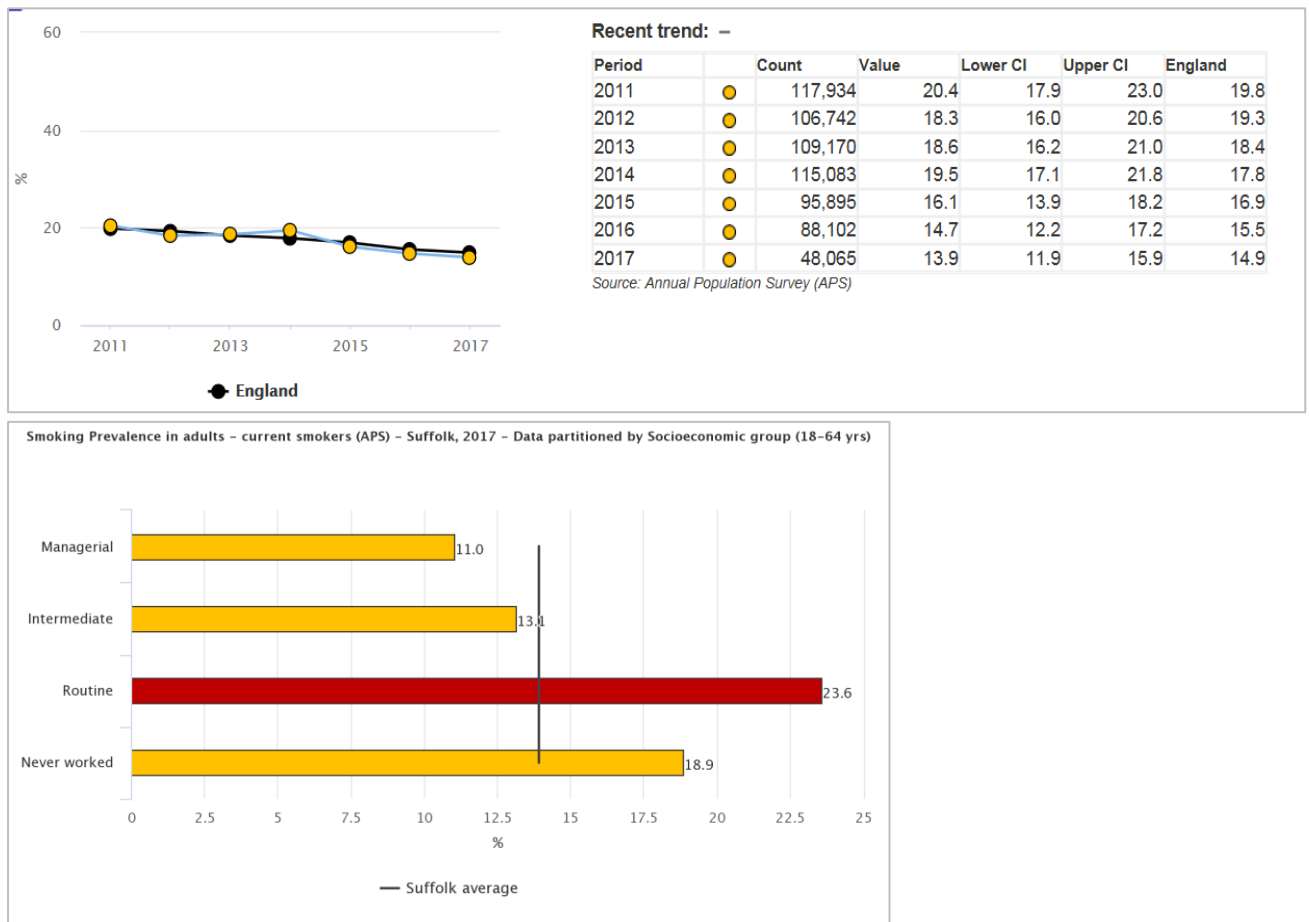
Indicator	Period	England	East of England region	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
Smoking Prevalence in adults - current smokers (APS)	2017	14.9	14.2	16.2	14.5	15.8	13.8	12.7	14.3	13.8	17.6	18.0	13.9	17.7

Source: Public Health England, Fingertips

National estimates from ONS in 2016 suggest that 10.6% of people aged 60 and over are smokers. If this applied to the latest over 60 Suffolk population figure, it would suggest that around 23,300 people aged 60 and over in the county currently smoke.¹⁴

When comparing smoking prevalence trend over time, it is evident that Suffolk’s smoking prevalence has decreased over the years apart from a slight increase that occurred in 2014. However, there are **inequalities** in smoking prevalence that still exist. The prevalence of smoking in adults rises to 23.6% (over 1 in 5) for those working in routine and manual occupations and to 38.6% for those with a serious mental illness (Figure 22).

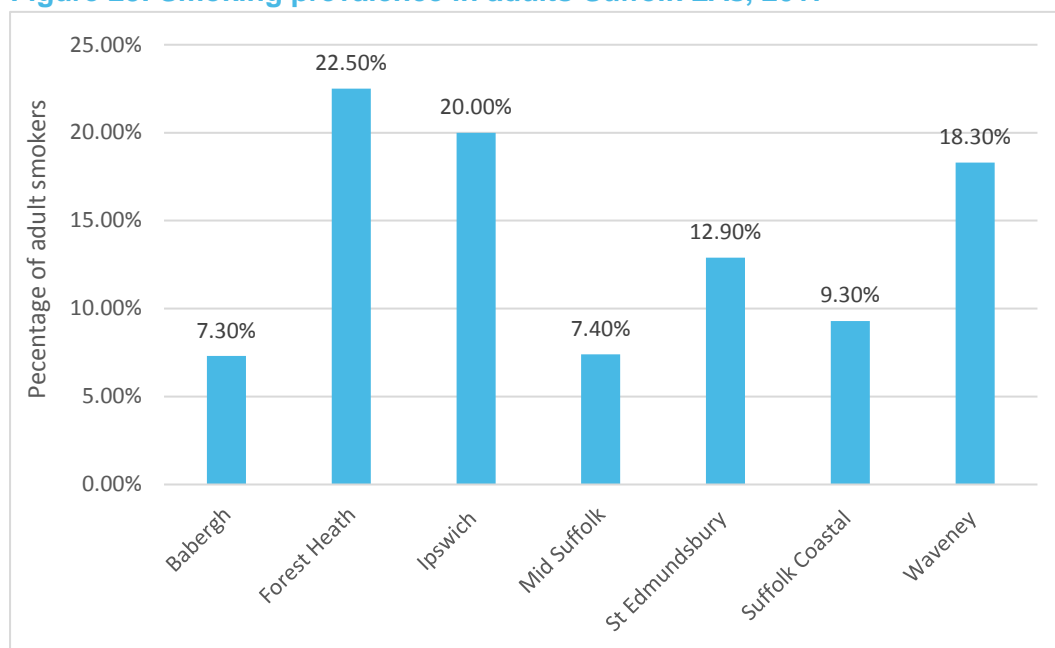
Figure 22: Trend in smoking prevalence in adults and smoking prevalence by socioeconomic class, 2017



Source: Public Health England, Fingertips, 2017

There are further variations within the adult smoking prevalence for Suffolk LAs. Across LAs in Suffolk, Babergh has the lowest adult smoking prevalence (7.3%-significantly lower than England) and Forest Heath has the highest at 22.5% (statistically similar to England). Smoking prevalence is also markedly high in Forest Heath (20.4%) and Ipswich (20.0%); indicating that the proportion of adults who smoke in Suffolk varies from 1 in 12 in Babergh to 1 in 5 in Forest Heath and Ipswich. The smoking prevalence estimates for Waveney, Forest Heath and Ipswich are all higher than the England average of 14.9% (though not significantly higher). An explanation as to why these areas are higher, may be that these areas map to Suffolk's most deprived areas (Figure 23).

Figure 23: Smoking prevalence in adults-Suffolk LAs, 2017



Source: Public Health England, Local Tobacco Profiles

PHE available data shows that the potential life years lost due to smoking related illnesses is 1,150 per 100,000 persons for Suffolk, this is less than both the regional and national averages.

3.3.1 Inequalities in smoking prevalence

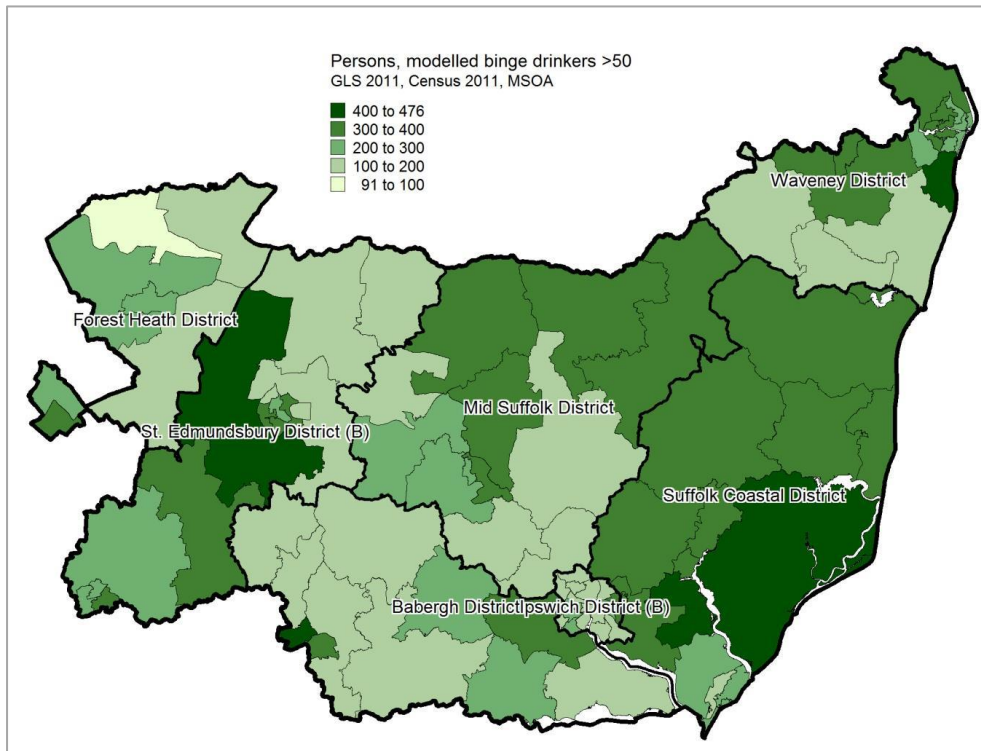
There are number of inequalities in smoking prevalence across Suffolk and these will have implications for older generations:

- People living in deprived areas are more likely to smoke.
- The latest available quit data (2016/17) indicates that compared to England, Suffolk falls in the middle quintile of people setting a quit date, and successfully quitting at four weeks.
- Smoking accounts for about half of the difference in life expectancy seen between our lowest and highest income groups.
- Smoking rates in adults with depression are approximately twice as high as among adults without depression.

3.4 Alcohol

Data regarding Suffolk's alcohol usage in older people specifically is scarce, however the risk that alcohol poses means that it must be considered in assessing health needs. In 2016 an ['Alcohol in those aged 50+ Needs Assessment'](#)⁴ was undertaken which contains more detailed information and is available on the [Healthy Suffolk website](#). In the absence of local figures on rates of drinking in older people, these were modelled on binge drinking rates (those who drank at least double the maximum recommended amount on at least one day in the week prior to being surveyed). Alcohol consumption in Suffolk showed a similar pattern and was marginally lower than in England. It showed particularly that alcohol consumption does appear to increase with age, and that consumption is higher among more affluent groups.⁴

Figure 24: The distribution of the modelled estimates of binge drinker at MSOA level, for persons, Suffolk, 2011

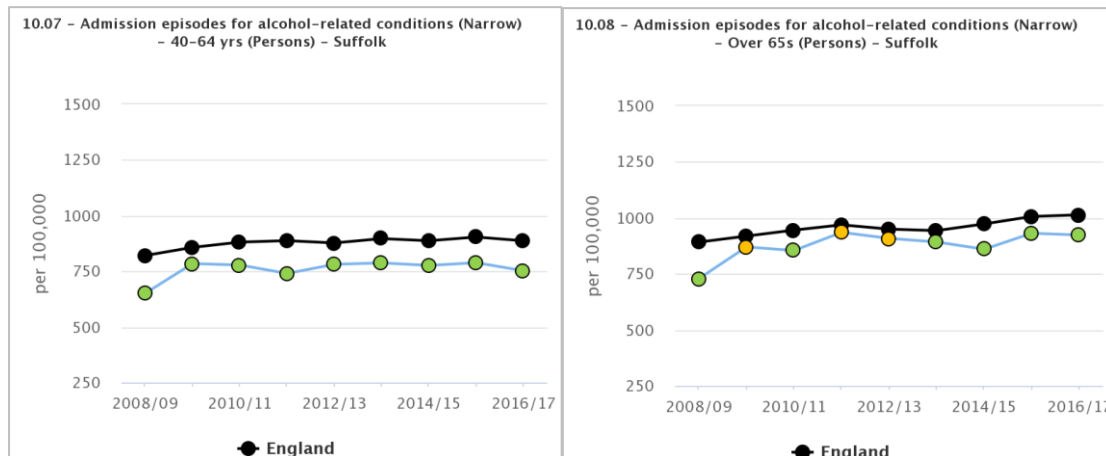


Source: Alcohol in those aged 50+-Suffolk Needs Assessment <https://www.healthysuffolk.org.uk/uploads/2016-04-28-Alcohol50-NA-V5.pdf>

Figure 24 shows modelled estimates correlate directly with population density, with the highest estimated levels of binge drinking in urban areas including Ipswich, Bury St Edmunds, Lowestoft and Newmarket.⁴

The figure below shows that 2016/17 hospital admission episodes in Suffolk for alcohol related conditions (under narrow definitions - defined as “admissions to hospital where the primary diagnosis is an alcohol-related condition, or secondary diagnosis is an alcohol-related external cause”) for those aged 40-64yrs is 752 per 100,000 persons, and for over 65’s is 923 per 100,000. These admission rates are lower than national averages but indicate increased admission rates in over 65’s compared to those aged 46-64. However, care needs to be taken when interpreting these findings, as this may also be indicative of a weaker alcohol tolerance, and increased sensitivity to the impacts of alcohol related conditions.

Figure 25: Trend in admission episodes for alcohol related conditions, 40-64 and over 65's, Public Health England

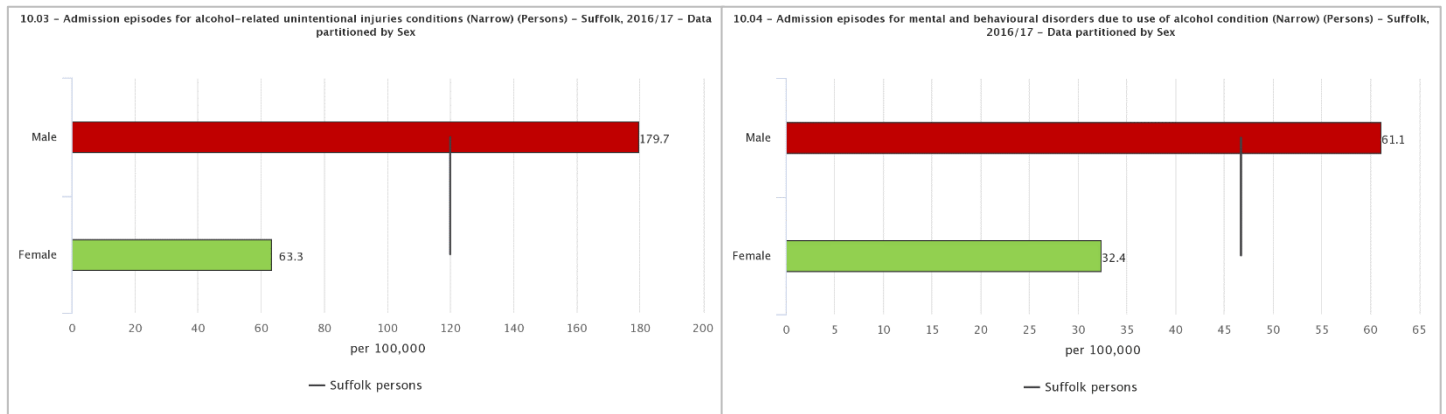


3.4.1 Inequalities in alcohol use

Public Health England’s alcohol profiles for Suffolk (2016/17) show that inequalities do exist:

- Admissions for alcohol related unintentional injuries are 2.8 times higher in males than females. (Figure 26)
- Years of life lost due to alcohol related conditions are 3.4 times higher in males than females, and alcohol related mortality is 2.4 times higher in males than females.
- Admissions for mental and behavioural disorders due to the use of alcohol is 1.9 times higher in males than females. (Figure 26)
- Alcohol consumption at a higher age results in higher hospital admissions.
- Admission episodes for intentional self-poisoning by and exposure to alcohol condition for females is significantly higher than both the national and regional averages at 79.0 persons per 100,000.
- A recent study by Alcohol Research UK has suggested that there may be unfair treatment of older people in 75% of residential alcohol treatment facilities in England, due to imposed age limits on entrance criteria. Continued neglect of older people’s access and quality of life at alcohol treatment services can result in an increase in preventable alcohol related mortality for older people.¹⁵

Figure 26: Admission episodes for alcohol-related unintentional injuries and mental and behavioural disorders due to alcohol, 2016/17



Source: Public Health England, Alcohol Profiles

A study by Iparraguirre et al, examined the socioeconomic determinants of risk of harmful alcohol drinking and of the transitions between risk categories over time from a longitudinal survey of over 50's.¹⁶ The findings showed different risk to men and women:⁴

Risks to men:

- There was an association between age and risk for men (falling with age), peaking in their mid-60s.
- Single, separated or divorced men show a greater risk of harmful drinking.
- Not eating healthily, being younger and having a higher income increase the probability of becoming a higher risk alcohol drinker.

Risks to women:

- Retirement and income were found to be positively associated with a higher risk for women but not for men.
- Women with caring responsibilities were at lower risk of their drinking increasing.
- In women, being younger and having a higher income at baseline was associated with increased probability of becoming a higher risk alcohol drinker over time.

Whilst there are challenges ahead, there are services available in Suffolk and nationally such as the NHS Health Checks programme and the National Diabetes Prevention Programme, which are large scale programmes aimed to prevent lifestyle associated health problems and are further explained in more detail in Section 7: Existing Services.

Summary: Individual lifestyle factors

Physical activity (PA) and obesity

- ❖ PA levels decrease as people get older. Nationally, only 1 in 10 males aged over 75 and 1 in 20 females aged over 75 meet the recommended guidelines for PA.
- ❖ Inequalities in PA exist in Suffolk. Women, individuals with a limiting illness or disability, from lower socio-economic classes and those who are unemployed are less physically active.
- ❖ Ill health due to physical inactivity costs the Suffolk system more than £17 million per 100,000 people per year.
- ❖ The number of older people who are predicted to be obese is expected to rise by a third in the next 20 years.
- ❖ There is variation in obesity prevalence which drive inequalities. Women of Black Caribbean and South Asian ethnicities are estimated to have higher obesity levels.
- ❖ Being obese can reduce an individual's life expectancy by up to 10 years, reduce one's overall quality of life and increases the risk of developing diabetes, cardiovascular diseases, and cancer. It has been associated with unemployment and can affect self-esteem and mental health.

Smoking:

- ❖ Nationally, it is estimated that 10.6% of people aged over 60 smoke.
- ❖ The proportion of adults who smoke in Suffolk varies from 1 in 12 in Babergh to 1 in 5 in Forest Health and Ipswich.
- ❖ Smoking rates are higher in adults working in routine and manual occupations and in those with depression and serious mental illness.

Alcohol:

- ❖ Alcohol consumption appears to increase with age, and that consumption is higher among more affluent groups.
- ❖ Higher-risk drinking is declining for all age groups bar the over 50's.
- ❖ A recent study by Alcohol Research UK suggests that age limits on entrance criteria to 75% of residential alcohol treatment facilities in England may limit access for older people and have an impact on preventable alcohol-related mortality in this age group.

Diet and Nutrition:

- ❖ In Suffolk, the adult consumption of fruits and vegetables is higher than national and regional averages.
- ❖ Undernutrition is a growing problem amongst older people, and research suggests diets rich in fruits, vegetables and nuts can reduce mortality in older people.
- ❖ About a third of patients admitted to hospital and 42% of patients admitted to care homes are at risk of malnutrition.
- ❖ In Suffolk, diabetes prevalence in adults is expected to rise by about 30% in the next 20 years.
- ❖ Several cancers have been attributed to comorbidity with diabetes and obesity. Having diabetes and a BMI of over 25 has been associated with liver cancer in men and breast cancer in women.

4. SOCIAL AND COMMUNITY NETWORKS

Case Study: Ellie – 81 years

ActivIpswich, a partnership between ActivLives and Ipswich Borough Council is funded by the National Lottery as part of Sport England's *Community Sport Activation Fund*. The project helps motivate and inspire people over 45 to make positive changes to their lifestyle through physical activity.

Ellie has been living in Suffolk for the past 55 years. She has had a variety of jobs including waitressing. Here is Ellie's Healthy Ageing Story:

What does positive ageing mean to you?

"Keep a positive (young) outlook. Keep yourself fit and active"

What do you do to keep fit, strong and healthy?

"When my husband passed on I joined some of the ActivLives/

ActivIpswich groups and I have never looked back – "that's the truth of the matter"

I feel sorry for people that don't or who can't get involved with this sort of activity. They don't know what they are missing!

Describe your experience participating in ActivIpswich.

"I regularly attend the ActivIpswich Kurling group at the town library and the Multi - Sport at the Whitehouse Community Centre. I love all of it, but I especially like to play table tennis – I love the activity and the feeling that it gives me. I really enjoy the competitions as well. I have won 4 medals which I keep in my cleaning cupboard – I know that sounds funny, but I show them off to people when they visit my house. It's a real talking point!

How do you feel afterwards, and how do you believe these experiences affect your life?

"The ActivIpswich sessions make my life to be honest. They give me something to look forward to. I have met so many lovely people and made a lot of new friends."

What advice or suggestions would you give to people younger than you, or even older than you who want to be healthier?

"Come and try some social sport with ActivLives, you will find that your life is turned around. It's brilliant!"



4.1 Social isolation and loneliness

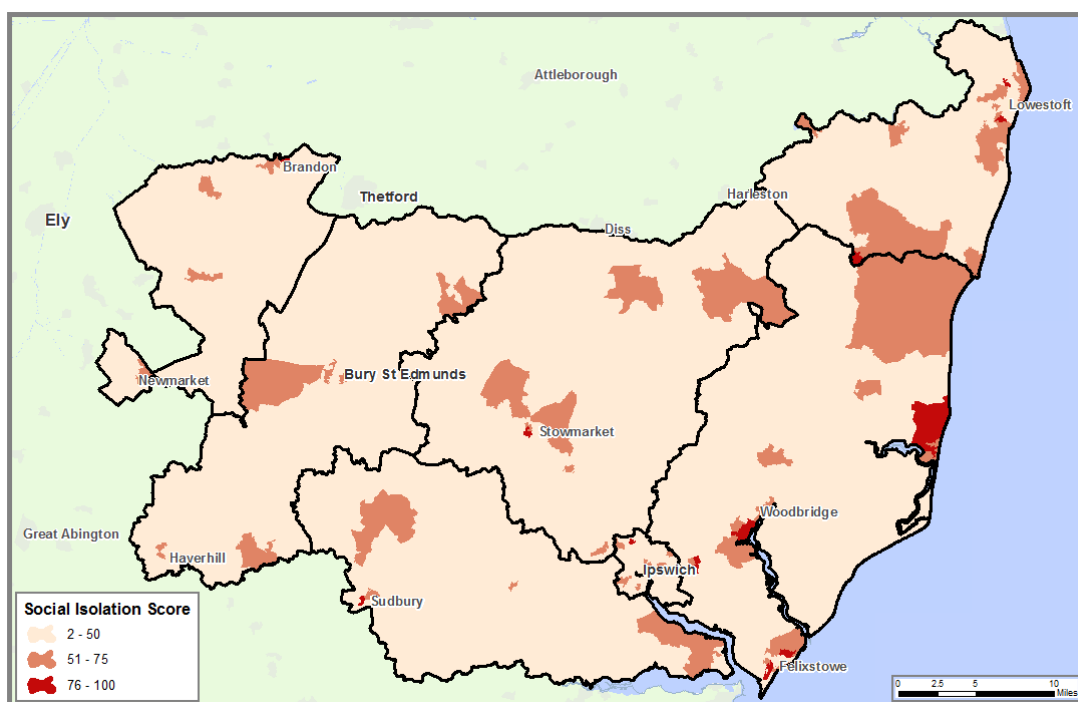
The Suffolk Health and Wellbeing Board Strategy has in one of its priorities a focus on reducing loneliness and social isolation among older people. A large-scale study by Holt-Lunstad et al analysed two large meta analyses on loneliness and its association on premature mortality; of which one meta-analysis found that greater social connection could present a 50% reduced risk of early death, and the other found that the role of social isolation, loneliness or living alone on mortality was equal to or exceeding that of obesity.¹⁷

Loneliness can be seen as *“an individual’s personal, subjective sense of lacking desired affection, closeness, and social interaction with others.”* However, loneliness is not the same as social isolation. Social isolation is considered to be the *“absence of social contact i.e. contact with friends or family or community involvement or access to services”*.¹⁸ Data shows that there are an estimated 17,000 older people who feel lonely ‘all or most of the time’, and 19,000 older people who feel isolated in Suffolk.¹⁹ Given that the older population is expected to rise in the next 20 years, there will be an estimated 25,000 older people in Suffolk who will feel lonely by 2037. Multiple studies have also implied that loneliness is higher amongst females than males. Public Health Suffolk undertook data analysis based on Age UK’s ‘risk of loneliness in England 2016’ interactive mapping tool, which found that there is a higher risk of loneliness for the over 65’s in urban areas of Suffolk, such as Ipswich and Mid Suffolk compared to other LAs.

It is estimated that the number of 65-74 year olds living alone in Suffolk will increase by 20.1% (from approx. 23,660 to 28,420) from 2017 to 2035. Those aged 75 years and over living alone will also increase by 69.6% (from 39,065 to 69,233) over the same period.⁵ This will potentially have a large impact on these estimates of loneliness and isolation amongst these older people.

Experian Mosaic data can be used to explore areas where social isolation is likely to be higher. A range of variables that are likely to increase social isolation are modelled and weighted to produce an overall “isolation score”. The isolation score is based on 16 standardised variables that included age, employment, car ownership, internet access, marital status, health problems amongst others. Each individual variable is weighted from 1-5, with the higher score indicating the higher likelihood of social isolation. The sum of all variables creates a score, which was then standardised across the LSOAs to create an isolation score of between 0 and 100. The “isolation score” can be seen as a percentage of isolation relative to the LSOA with the highest score. This has been used to map social isolation ‘hotspots’. These can be seen in the Figure 27 below and tend to be in rural areas to the East and South of the county, around Lowestoft, Woodbridge, Stowmarket, Felixstowe, Sudbury and Leiston.²⁰

Figure 27: Lower Super Output Areas (LSOAs) likely to experience higher levels of social isolation in over 65's in Suffolk (2016)



Source: Experian Mosaic data, Public Health Suffolk

Many studies both nationally and globally have found an association between loneliness and depression. There is also increasing evidence pointing towards an association between loneliness and dementia. In light of this growing problem, there have been studies, albeit a few, which have reported cost effectiveness of investing in interventions that target loneliness. The 'Campaign to End Loneliness' estimates the potential national costs of loneliness to health and care services, for a cohort of people aged over 65, to be in excess of £1,700 per person over a ten year period.²¹

4.2 Depression

Loneliness, social isolation and lack of community bonding play a role in the incidence of depression.²²

The use of specialist mental health services is higher in people aged 65 and over than would be expected based on the proportion of the populations nationally. Research has showed that in the UK older people living in care homes and admitted in hospital have a higher prevalence of depression than the general older population living in community dwellings, estimated to be around 20-30% and this depression is often in combination with dementia.²²

Some of the key issues regarding older peoples mental health nationally have been highlighted in the Chief Medical Officer's Report, 2013:²³

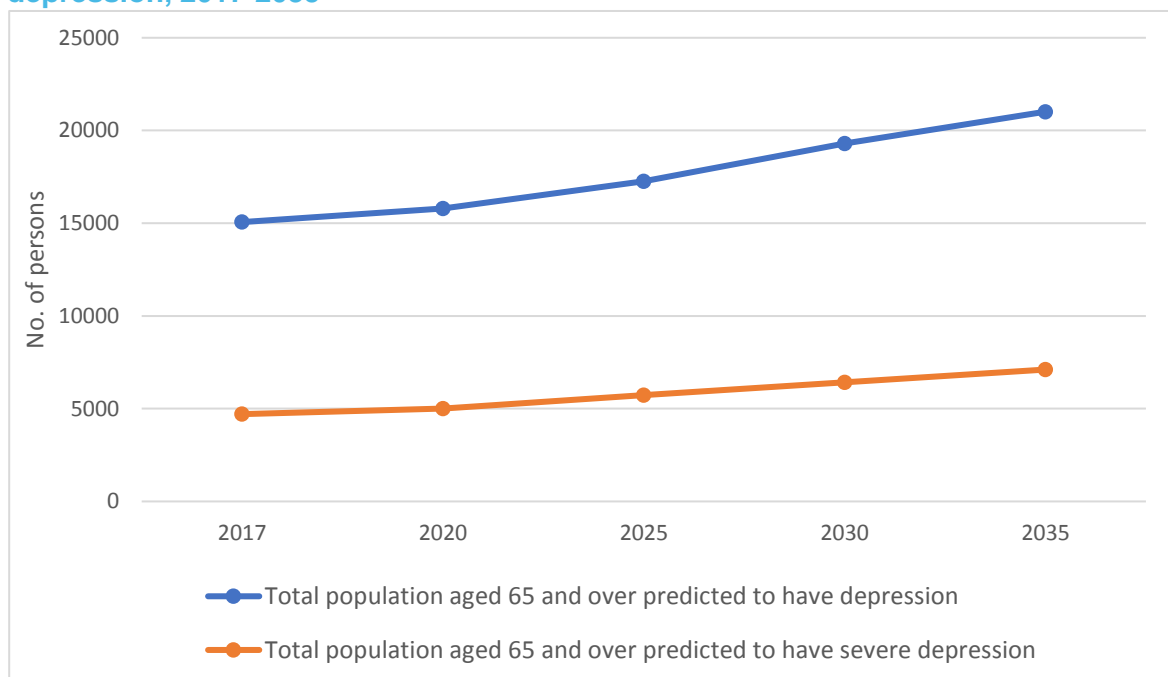
- Those with long term conditions such as stroke and Parkinson's disease can have levels of depression up to 50%.
- Statistics have shown that in older people aged 65 and over, having a serious mental illness is linked to higher death rates.
- Around 10-20% of people aged 65 and over have depression 'of clinical significance' i.e. at a level where a clinician would expect to intervene.

- In general, older people suffer from social isolation or have worse physical health conditions compared to younger people. As these are risk factors for depression, older people account for a higher proportion of cases.²²

Estimates of depression in older people in Suffolk are based on a high-level study of depression in older adults undertaken in 2007.²⁴ Within this study findings showed that depression was more common in women than men, and was associated with increasing age, disability, other medical problems, and deprivation. The projected estimates of depression in older people published in POPPI are based on the findings from this study. These are illustrated in Figure 28 below which shows that in Suffolk:

- The total number of people aged 65 and over predicted to have depression from 2017 to 2035 is expected to rise by approximately 43% (15,062 to 21,014).
- The total number of people aged 65 and over predicted to have severe depression from 2017 to 2035 is expected to rise by approximately 51% (4,706 to 7,110).
- Total number of people aged 85 and over with depression is predicted to rise 109% from 2017-2035.

Figure 28: Persons aged 65 and over predicted to have depression and severe depression, 2017-2035



Source: Projecting Older People Population Information (POPPI)

As seen above, the prevalence of depression is expected to increase as people get older, and this will have several implications on health outcomes. There are number of risk factors for depression which can also lead to suicide: poor physical health, loneliness and social isolation. It is common knowledge that older people are more likely to have physical health conditions. However, this combined with depression can lead to poor outcomes in illnesses such as myocardial infarction (MI), stroke and hip fractures and even higher mortality rates. Older people experiencing mental ill health may find it especially challenging accessing health care as they may suffer from loneliness, stigmatisation and poor mobility, resulting in poor quality

of life. Evidence also shows that that 90% of people with mental health problems suffer from discrimination and stigma, even more so in certain minority groups.²²

What can be done:

The World Health Organisation states that focusing on improving the wider determinants of health that affect an older person can lead to improving their mental health. These can include:

- providing security and freedom;
- supportive housing policy;
- social support for older people and their carers;
- programmes targeted at vulnerable groups e.g. those who live alone and rural populations;
- support for those with chronic mental or physical illness.²²

People experiencing mental ill health, often show positive outcomes following treatment, therefore it is essential the health and care system accommodate older people by improving access to services and supporting organisations offering befriending services to those otherwise isolated and lonely.²²

Summary: Social and community networks

- ❖ Studies suggest that greater social connection could reduce the risk of early mortality by 50%. The impact of social isolation, loneliness or living alone on mortality has also been estimated to be equal to or exceeding that of obesity.
- ❖ In Suffolk, an estimated 17,000 older people feel lonely, and this is expected to rise to 25,000 older people in the next 20 years.
- ❖ Over 65's living in urban areas in Suffolk e.g. Ipswich and in Mid Suffolk face a higher risk of loneliness compared to other districts.
- ❖ The total population aged over 75 predicted to live alone by 2035 is expected to rise by approximately 70%.
- ❖ An estimated 19,000 older people in Suffolk feel socially isolated. The 'hotspots' for social isolation in older people in Suffolk tend to be in rural areas to the east and south of the county, around Lowestoft, Woodbridge, Stowmarket, Felixstowe, Sudbury and Leiston.
- ❖ Loneliness, social isolation, and lack of community bonding have been associated with depression. Loneliness has also been associated with dementia.
- ❖ Forecasts estimate a ~43% increase in those aged 65 and over in Suffolk predicted to have depression by 2035. This rises to ~109% increase in those aged 85 and over.
- ❖ Older people with mental ill health may find it challenging accessing health care as they may suffer from loneliness, stigmatisation and poor mobility, resulting in poor quality of life. Additionally, evidence shows that that 90% of people with mental health problems suffer from discrimination and stigma, even more so in certain minority groups.

5. CARE AND HEALTH CONDITIONS

Case Study: Sarah- Late 70's.

Sarah is from the Midlands, and although not from Suffolk she is a Carer who is ageing well despite facing difficulties in life.

Sarah is a carer who looks after her husband who has Parkinson's disease. She continued working until she was 70 and was partaking in regular physical and recreational activity.

Now Sarah provides almost all the care for her husband, who also had a fall two years ago and suffered from a broken hip. Due to these care responsibilities and her husband's immobility problems, over the years Sarah and her husband have become socially isolated and almost inactive.

Following a carer's assessment, she was advised that engaging in activities again would improve her own deteriorating health and wellbeing. Initially apprehensive to leave her husband, with the view it was her responsibility to oversee her husband's care 24/7 she agreed.

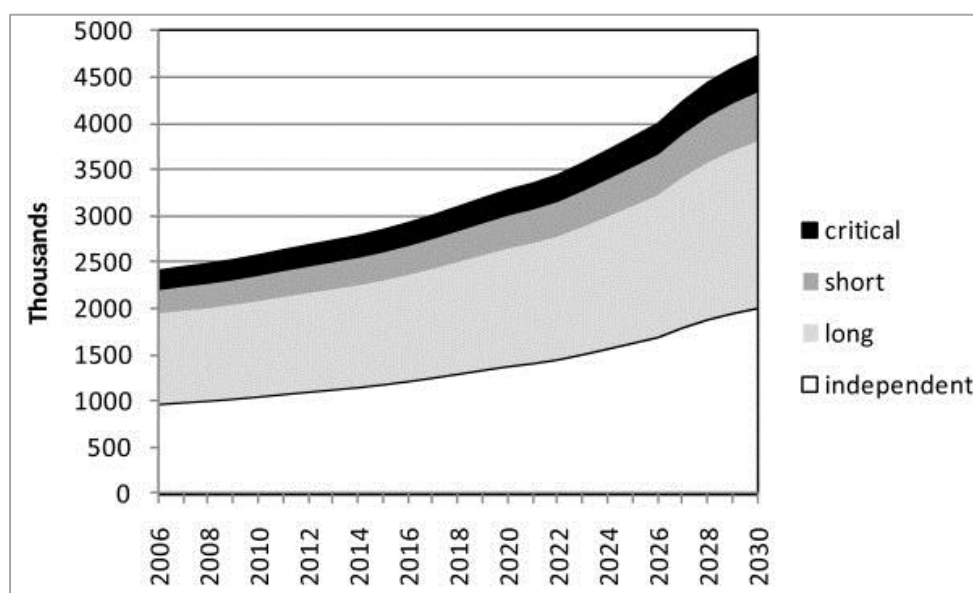
Over time, Sarah now has willingly accepted more services and now partakes in recreational activities such as the theatre once a month, which she states gives her a great deal of relaxation and enjoyment.

Source: [https://professionals.carers.org/sites/default/files/improving_health_outcomes - older carers voices and stories.pdf](https://professionals.carers.org/sites/default/files/improving_health_outcomes_-_older_carers_voices_and_stories.pdf)

5.1 Dependency in the older population, trends and forecasts

County level data for dependency is scarce, however there have been highly accredited national studies that have focused on this topic. Within the high level ongoing Cognitive Function and Ageing Study (CFAS),²⁵ the Newcastle 85+ cohort study modelled projections of future care needs for older people.²⁶ Figure 29 shows the difference in dependency levels (critical, short, long, independent) from 2006 to 2030 for those aged over 80 in England and Wales. Participants were allocated a category depending on an allocated score based on the concept of ‘interval of need’. The four categories that were used were: independent dependency (participants for whom supervision or help for any activity was not essential); long-interval dependency (required help less often than daily); short-interval dependency (required help at regular intervals each day) and critical-interval dependency (required 24-hour care since help required potentially at any time or participant required constant supervision).

Figure 29: Dependency levels (critical, short, long, independent)-over 80’s, 2006-2030, England



Source: Jagger et al. *Capability and dependency in the Newcastle 85+ cohort study-Projections of future care*

Between 2010 and 2030, the number of people aged 85 with a ‘critical-interval dependency’, is projected to rise by 82%, and by 83% for 85 years olds with a ‘short-interval dependency’ need. The number of 80+ year olds who are ‘independent’ is also projected to rise by 94%. The number of care-home places required in 2030 in England and Wales is projected to be 630,000.

For participants living at home and in care homes, higher levels of interval-need dependency were significantly associated with: hospital admission and the use of respite care. For participants living at home, higher levels of interval-need dependency were significantly associated with contact with home-care services in the previous 4 weeks.²⁵

Section “5.7: Frailty” in this report contains Suffolk level data on immobility and self-care activity.

5.2 Care and care homes

Care homes in the UK provide 'accommodation, together with nursing or personal care for persons who are or have been ill, who have or have had a mental disorder, who are disabled, or are or have been dependent on alcohol or drugs'.²⁷ Care home residents therefore quite often have complex medical needs.

There are multiple challenges that the care homes sector face, which as a result are having implications on how people's care needs are met. Some of the challenges include; the number of residents in care homes (440,000) is three times more than the number of hospital beds (140,000) in England, there are continued cuts to LA funding, and a falling healthy life expectancy which research shows can lead to more dependency in later life. Almost all government papers on the care of older people have highlighted that the existing system of care homes is failing to meet patient needs.²⁷

There are also national level inequalities that have been identified:

- Large population-based UK studies have reported a one year mortality rate of 26% for care home residents as measured from the date of entry.²⁸
- Average life expectancy has been calculated at 1 year for nursing home residents and 2 years for those living in residential homes.

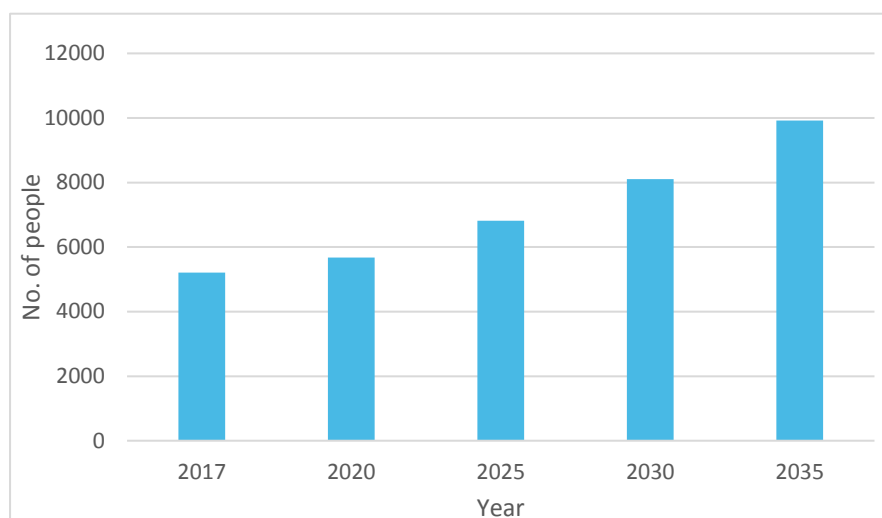
Furthermore, according to Care Quality Commission (CQC) inspection reports for Suffolk care homes, in 2017, 22% of the total care homes in Suffolk were rated as inadequate or requiring improvement. Whilst this is a marked improvement to the 2016 figure of 40%, this all clearly demonstrates the need for initiatives to improve the quality of care for care home residents.

5.2.1 Suffolk profile and projections

Older people living alone, can potentially require extra caring or dependency needs. As mentioned before, data from POPPI shows that the Suffolk aged 75 years and over is predicted to increase by ~70% in the next 20 years.

POPPI has also provided projections on the number of people aged 65 and over expected to live in a LA or non-LA Care Home. A LA care home is funded by the local council, whereas a non-LA care home is funded through private companies, NHS or voluntary organisations. Figure 30 shows that total over 65+ population living in a LA/non-LA care home is expected to rise by around 90% from 2017 to 2035 (5,207 to 9,917).

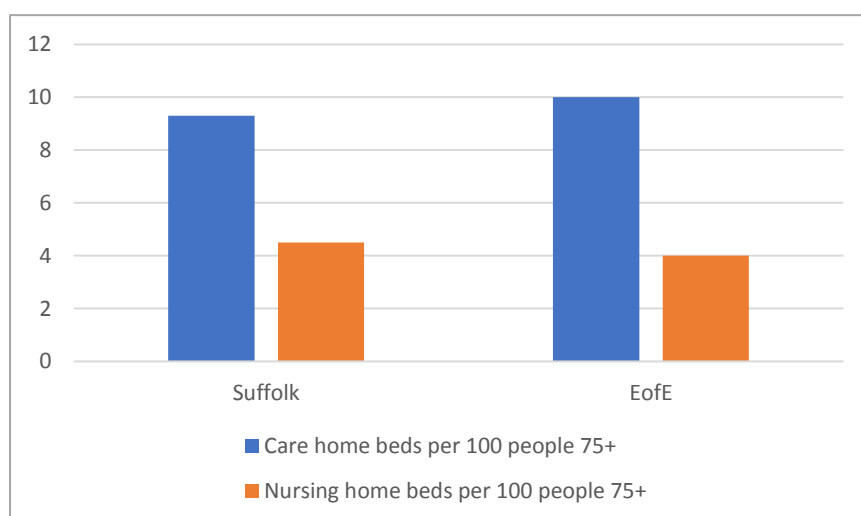
Figure 30: Population aged 65+ predicted to live in a care home (LA/non-LA) 2017-2035



Source: Projecting Older People Population Information, (POPPI)

Data from PHE shows that for people aged 75 and over in Suffolk, there are nine care home beds available per 100 people and 4.5 nursing home beds available per 100 people (Figure 31). This is lower than the regional average for care homes but higher than the regional average for nursing homes.

Figure 31: Number of care/nursing home beds per 100 people aged 75+, 2017



Source: Public Health England, Fingertips

In ongoing work on health and social care integration, the Suffolk system has committed to trying to keep people independent for as long as possible in their own homes. This will hopefully delay or prevent people needing care in a nursing or residential care home. The future projections relative to current availability of good quality residential and nursing home care suggest that a lot more needs to be done to avert a crisis in the future.

The Competition and Markets Authority's (CMA's), recently published a report stating the Care Home Sector is worth around £15.9 billion a year, with over 400,000 residents, and cannot be sustained without additional funding.²⁹ One of the main problems identified was the lack of information and support available to residents and families when choosing care homes,

leading to poor consideration of care needs. The report suggests a number of actions to address these problems, some of which include:

1. Providing people with good quality, relevant and timely support when they are making life-changing decisions about care.
2. Helping people quickly and easily identify the relevant, local care options that are available to them.
3. Encouraging and helping people to prepare and plan for future care needs.

5.3 A&E attendances/emergency admissions and reasons for admissions

Analysis from data provided from April 2015 to July 2017, shows that out of care home residents from all providers of both Suffolk CCGs, IESCCG had the highest number of *A&E attendances* for the care home residents. It must be noted that this is expected due to a higher population size, and a higher number of care homes. Figure 32 and 33 show both CCGs have higher attendances and admissions for those aged 85+ compared to 65-74 years, as expected:

- There has been an increase in A&E attendances by care home residents in IESCCG of around 7% amongst those aged over 85 from 2015/16 to 2016/17; for WSCCG the increase was 6%. (Figure 32)
- A similar pattern is also observed for the number of emergency admissions for care home residents. It should be noted that data for the 2017/18 period was only available from 2017 April-July, so has not been included for comparison purposes. (Figure 33).

Figure 32: No. of A&E attendances for care home residents-IESCCG and WSCCG- (all providers)

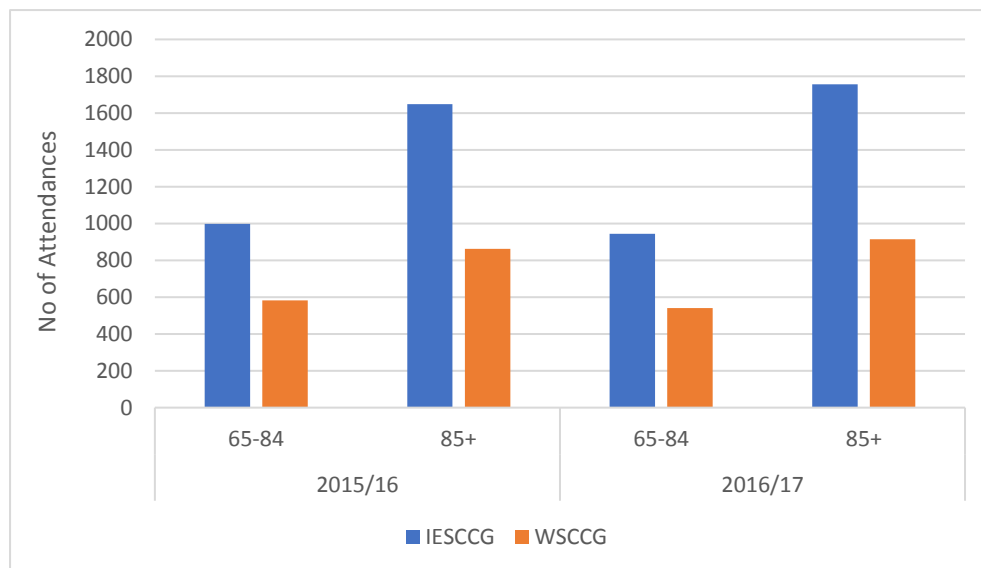
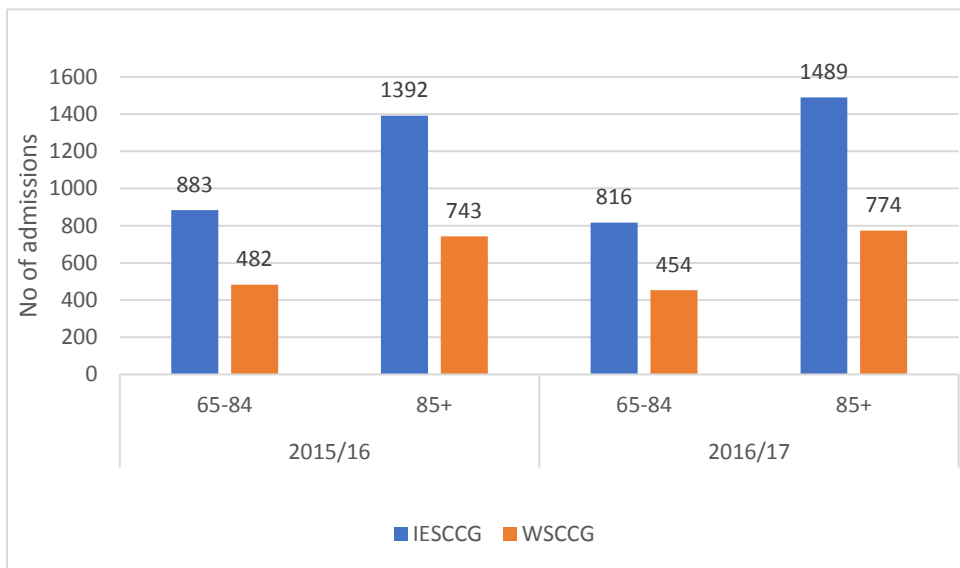


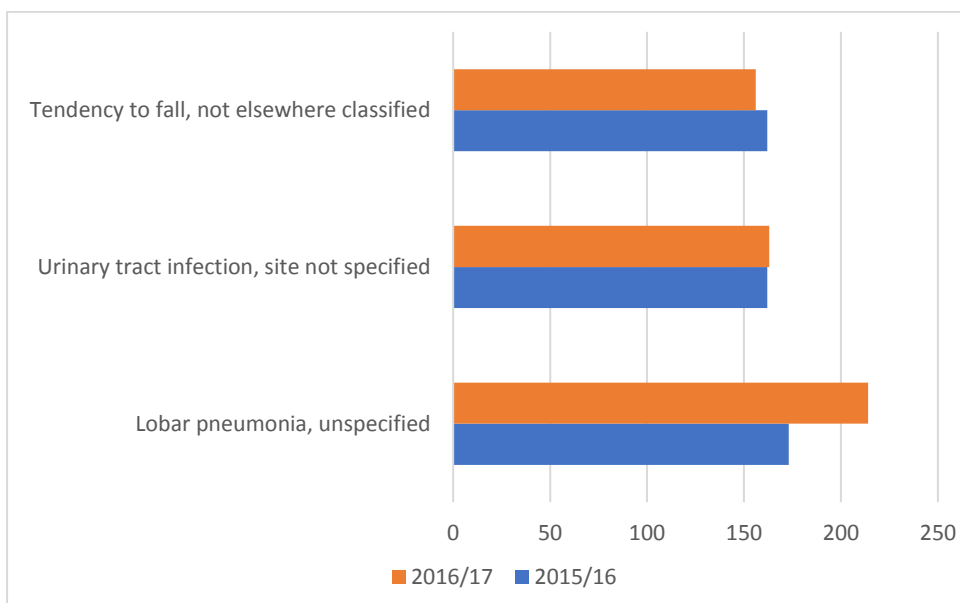
Figure 33: No. of emergency admissions for care home residents-IESCCG and WSCCG



Source: IESCCG and WSCCG Care Homes data analysis

For both CCGs, the top primary diagnosis for emergency admission for care home residents was due to ‘lobar pneumonia’. Lobar pneumonia as a diagnosis for emergency admissions of care home residents in IESCCG has increased by 23% from 2015/16 to 2016/17. For IESCCG, the next two top diagnoses were ‘urinary tract infection’ and ‘tendency to fall’. Of note is that, falls is consistently in the top 3 primary diagnoses for care homes residents’ emergency admissions. (Figure 34)

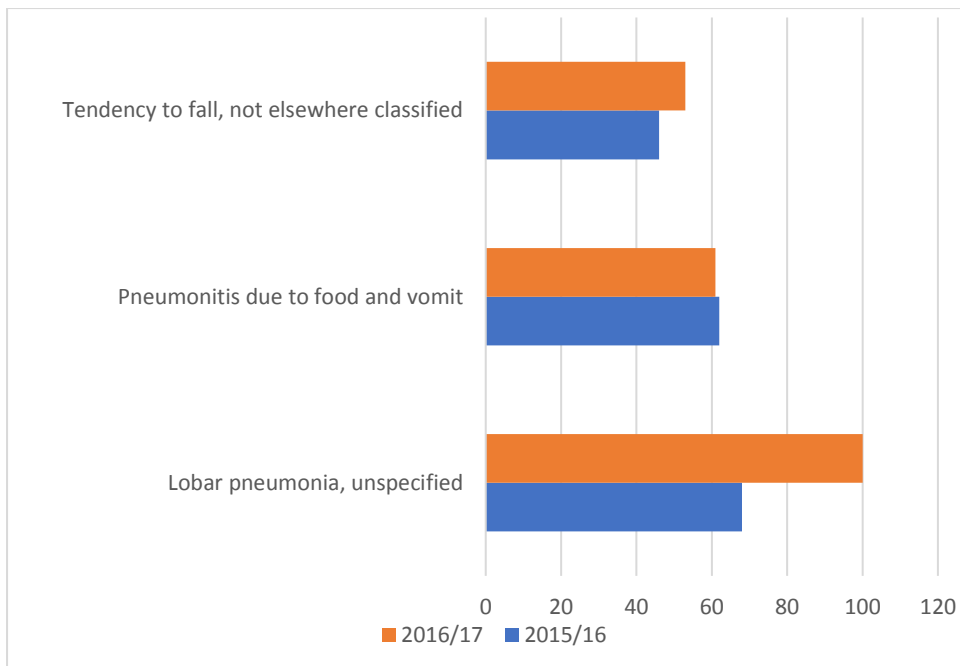
Figure 34: Care home residents-emergency admissions top 3 primary diagnosis-IESCCG



Source: IESCCG and WSCCG data analysis

Figure 35 below shows that for WSCCG care home residents, emergency admission reasons after the top diagnosis of ‘lobar pneumonia’ are due to ‘pneumonitis due to food and vomit’ and ‘tendency to fall’. Once again of note is that all of these primary diagnoses have increased from 2015/16 to 2016/17, and lobar pneumonia as a primary diagnosis has increased 47% from the previous year.

Figure 35: Care homes residents-emergency admissions top 3 primary diagnosis- WSCCG



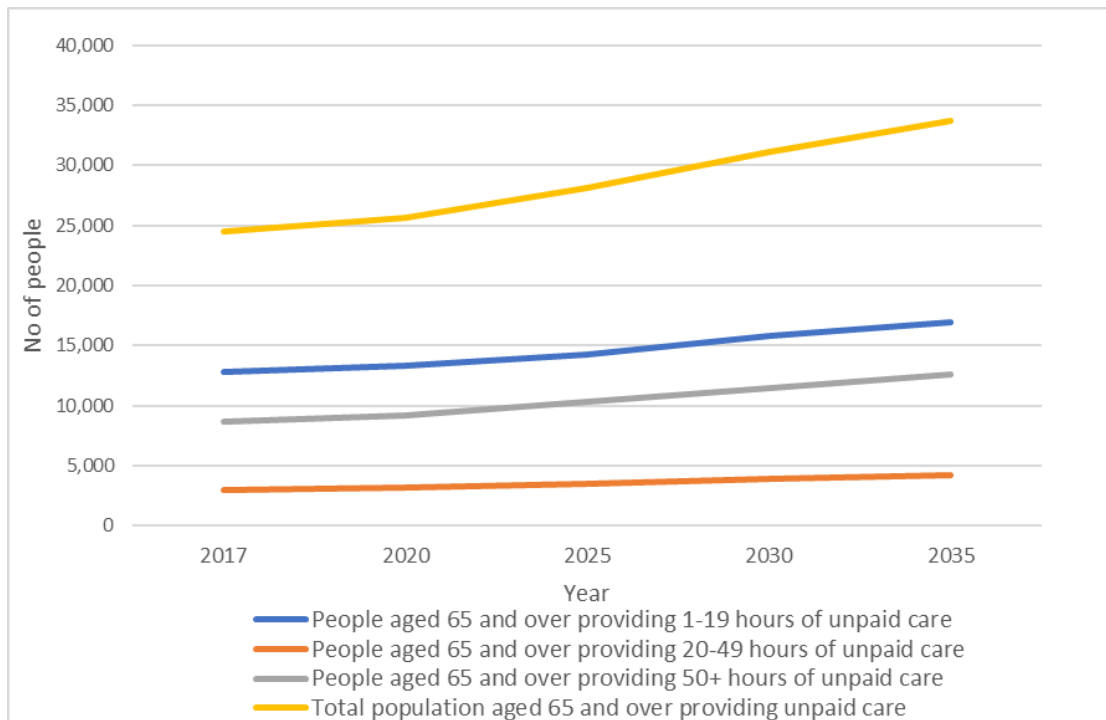
Source: IESCCG and WSCCG data analysis

5.4 Carers

At the 2011 Census, a total of 10.7% of usual residents in Suffolk County reported that they provided 1 or more hours of unpaid care per week. This is compared with 10.2% in East of England and 10.2% in England as a whole.³⁰ Within local authorities in Suffolk, the proportion of adults residents reporting that they provided 1 or more hours of unpaid care per week ranged from 11.9% in Suffolk Coastal to 8.3% in Forest Heath.

POPPI is able to predict the population aged over 65 who will be expected to provide between 1-50 hours of care from 2017 to 2035. Figure 36 below shows that the total population aged 65 and over providing unpaid care is currently 24,455 and is expected to rise by around 38% (to 33,679) in 2035. Furthermore, the total Suffolk population aged 65 and over providing over 50 hours of unpaid care in 2017 was approximately 8,648 and this is expected to rise by 27% (12,544) in 2035.

Figure 36: Predicted population aged 65 and over providing 1-50+ hours of unpaid care in Suffolk

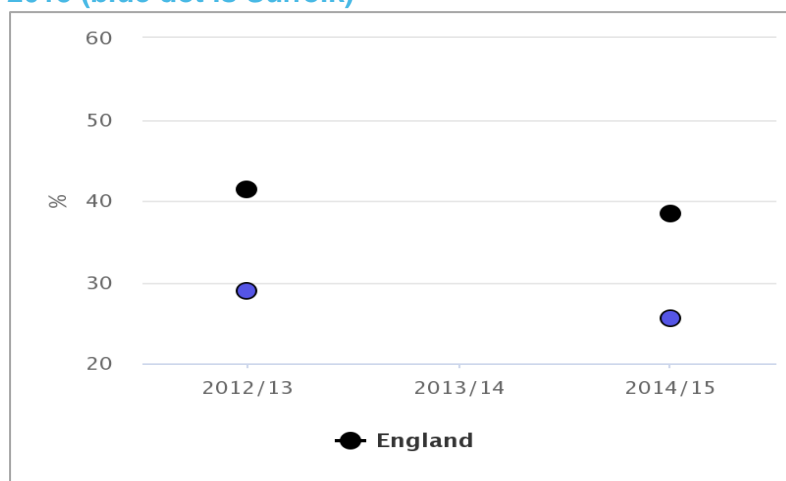


Source: Projecting Older People Population Information, (POPPI)

Carer quality of life

To give an indication of the quality of life of carers, the 'Adult Social Care Outcomes Framework' (ASCOF) includes a Survey of Adult Carers England (SACE). Responses from this survey shows that the percentage of adult carers 'who have as much social contact as they would like' in Suffolk has reduced from 28.9% to 25.6% from 2012/13 to 2014/15. This is also considerably lower than the England average of 38.5%. (Figure 37)

Figure 37: % of adult carers who have as much social contact as they would like 2012-2015 (blue dot is Suffolk)



Source: Public Health England, Fingertips

The 2016/17 SACE Survey has been published. From the Survey, the key findings and issues for Suffolk are below. (It must be noted that these figures may not be representative of the whole of Suffolk-as they are dependent on the response rate to this Survey).

- The top reasons for why people are cared for by a carer was for a physical disability (54.9%) followed by 40.9% due to a longstanding illness.
- 29.7% of carers (the highest reported percentage) reported feeling 'quite satisfied' with the support they or the person they care for has received in the last 12 months.
- 81.9% of carers reported that they were not able to take a break from caring at short notice or in an emergency as the person they were caring for has not used any support or services.
- 13.6% of carers reported that they were concerned for their personal safety compared to 85.6% who reported no concerns.
- 54.3% of carers reported having some social contact with people but not as much as they would like while 20.9% of carers reported feeling that they had 'little social contact with people and feel socially isolated'.
- When asked, 'has your health been affected by your caring role in anyway in the last 12 months', disturbed sleep, feeling tired and a general feeling of stress were reported as the leading reasons for health being affected.
- In terms of the general health profile of carers, 31.8% of carers reported suffering from a long-standing illness, but the majority 39.2% reported none of the above.

Improving the quality of life for carers, should be seen as a high priority area for ensuring healthy ageing. The Carers needs assessment in 2014 identified a number of ways this could be achieved.

- Telecare and telehealth have the potential to reduce carer stress, promote independence of the cared for and help people sustain their caring role for longer.
- Carer Support Workers to be linked with GP surgeries.
- Access to breaks services, can leads to significant reductions in carer strain, psychological morbidity and have the potential to delay permanent admission into permanent residential care.

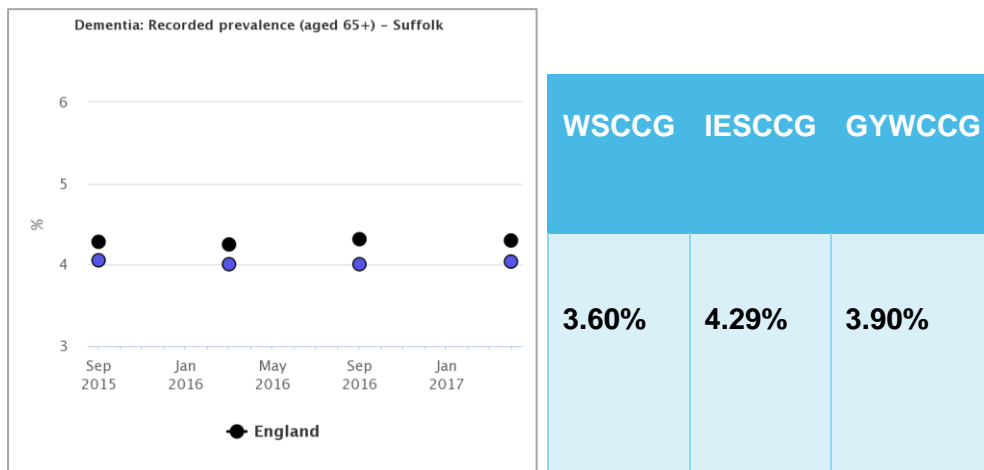
5.5 Dementia

Dementia is a syndrome characterised by impaired cognitive functioning and is most common in older people.

5.5.1 Prevalence

Current available data shows that as of September 2017, the dementia recorded prevalence rate (aged 65 and over) was 4% of Suffolk, which has remained almost the same since 2015. (Figure 38)

Figure 38: Dementia recorded prevalence (aged 65+) in Suffolk and 3 CCGs, Sept 2017

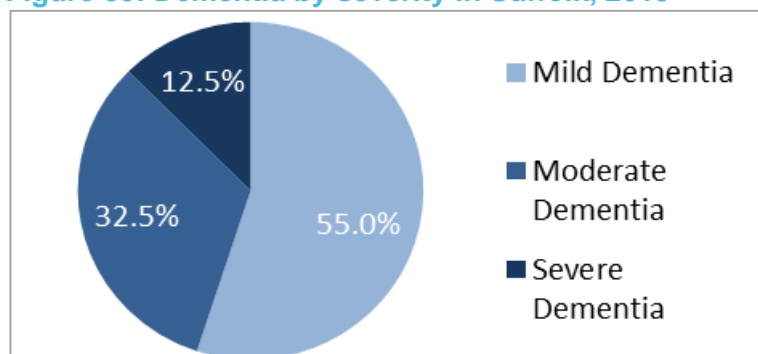


Source: Public Health England, Jan 2017

IESCCG has the highest Dementia Prevalence rate (4.29%) and WSCCG has the lowest (3.60%). Suffolk and North East Essex STP has a prevalence rate of (4.00%). However, it must be noted that this is the 'recorded prevalence' taken from Quality Outcomes Framework (QOF) so may be reflective of the completeness of records or higher diagnosis rates.

In 2016, Suffolk County Council undertook a Dementia Needs Assessment³¹ refresh using a specific methodology to calculate dementia prevalence and incidence. From this it was estimated that in Suffolk, 55% of all aged people have the disease of mild severity, 33% of people have disease of moderate severity, and 13% of people have severe disease. (Figure 39)

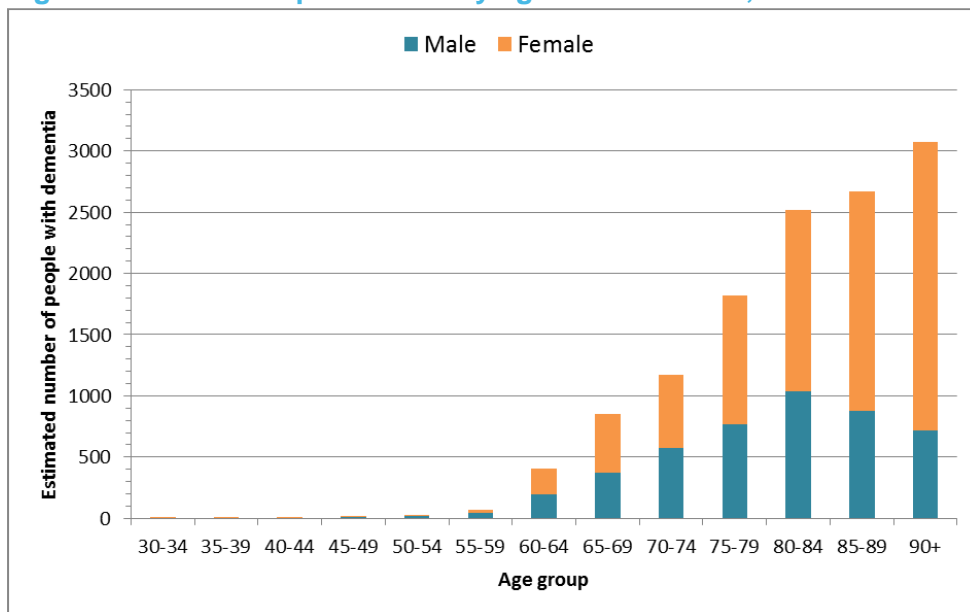
Figure 39: Dementia by severity in Suffolk, 2015



Source: Dementia Needs Assessment Refresh, Public Health Suffolk, 2016

The latest Dementia diagnosis rate (aged 65 and over, 2017) in Suffolk is 63.3% which is the same as East of England but lower than England average at 67.9%. There is more recent data for CCGs as of January 2018, which shows WSCCG has a significantly lower rate at 61.9% to the England average, whereas IESCCG and GYWCCG have statistically similar rates at 66.6% and 62.8%. Additionally, there is a higher prevalence of dementia with increasing age and amongst females which can clearly be seen below in Figure 40, with over three quarters of the people aged over 90 with dementia being female.³¹

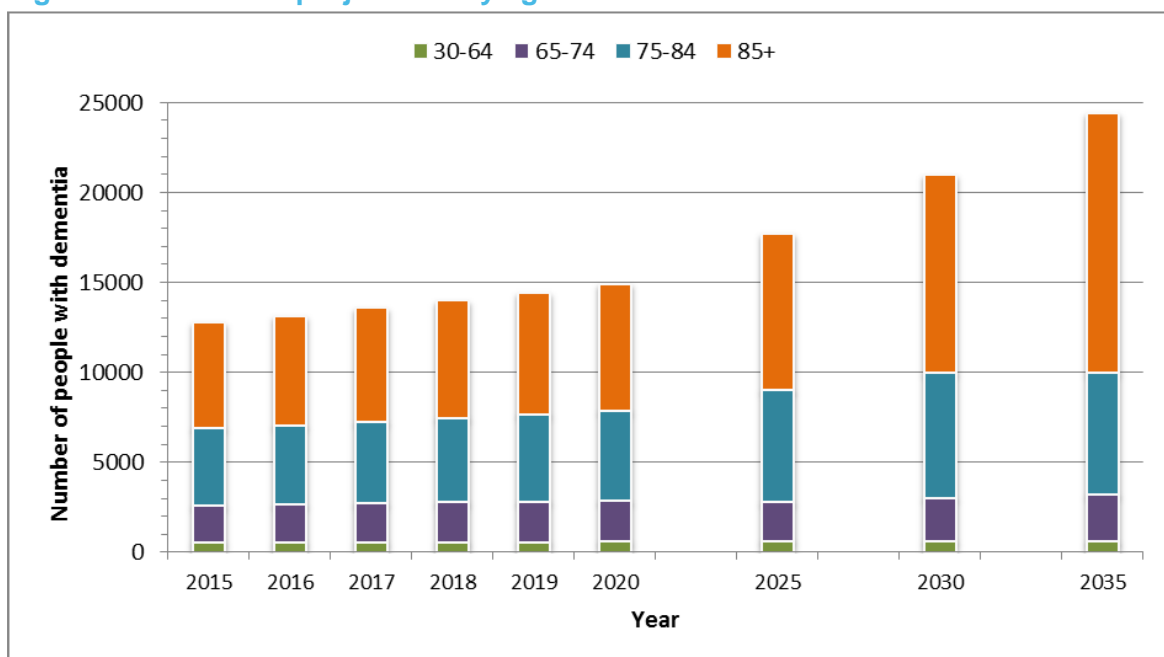
Figure 40: Dementia prevalence by age band and sex, 2015



Source: Dementia Needs Assessment Refresh, Public Health Suffolk, 2016

5.5.2 Dementia projections

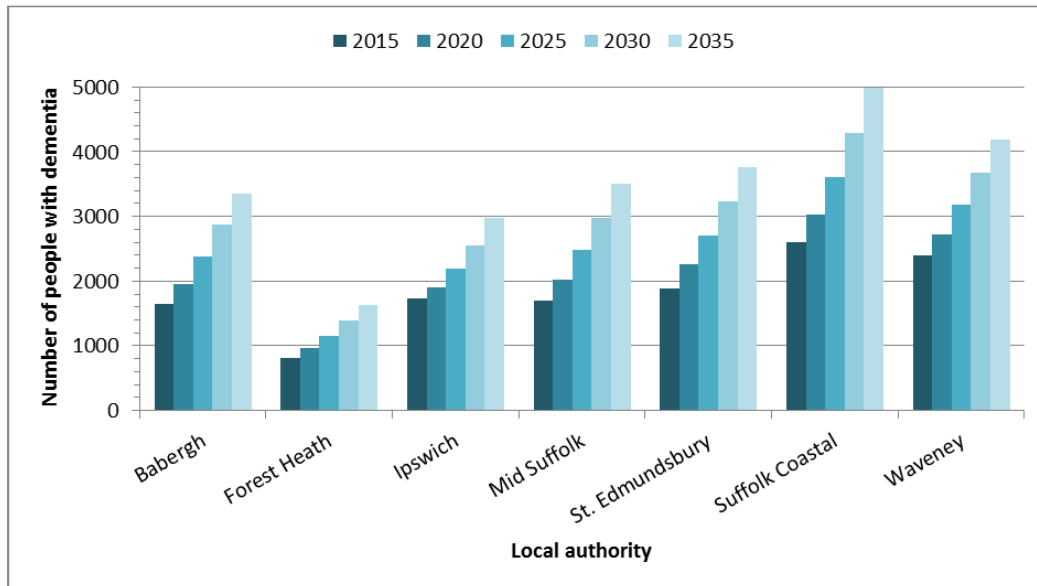
Figure 41: Dementia projections by age band from 2015-2035



Source: Dementia Needs Assessment Refresh, Public Health Suffolk, 2016

Figure 41 shows how the greatest increase in the number of people with dementia is expected to occur in people aged 85 and over. There will be nearly two and a half times the number of people with dementia in that age group by 2035 compared to 2015.

Figure 42: Dementia projections (all ages) by Suffolk LA, 2015-2035

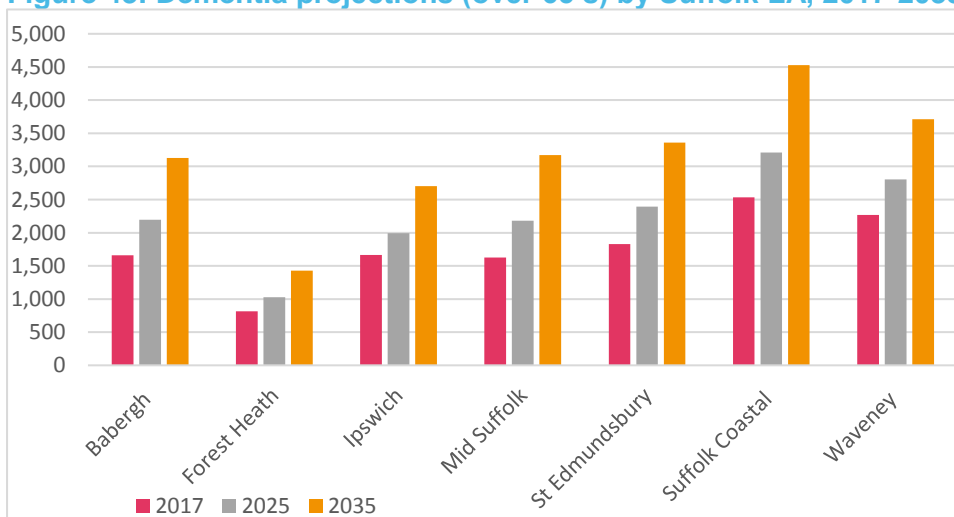


Source: Dementia Needs Assessment Refresh, 2016

Figure 42 above shows the districts of Mid Suffolk and Babergh will see the highest proportionate increases in the number of people (of all ages) with dementia between 2015 and 2035 (107% and 104% respectively), but that the Suffolk Coastal district will have the highest total number of people with dementia by 2035, predicted to be nearly 5,000 people.

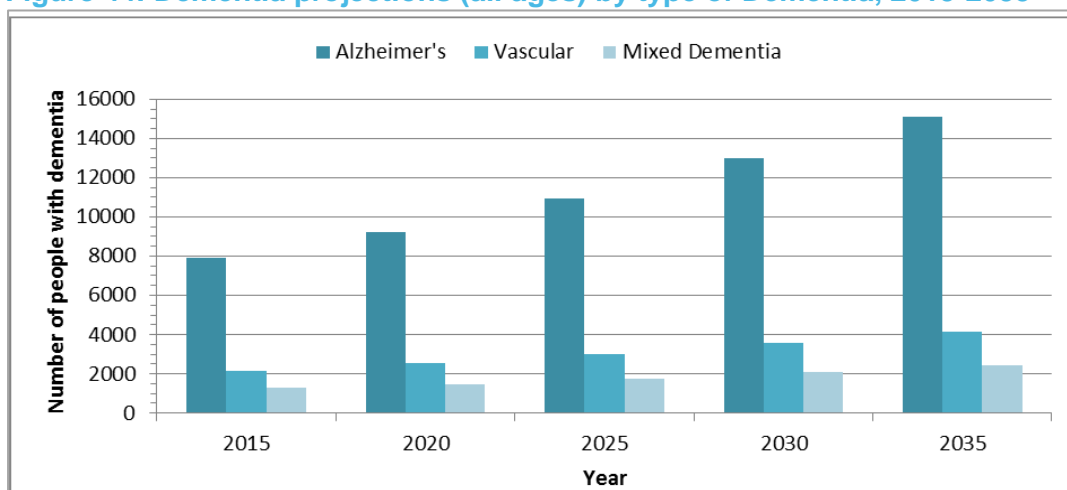
Looking at the over 65 population specifically, dementia projections provided by POPPI, Figure 43 below shows that from 2017 to 2035, all Suffolk local authorities are expected to see a vast increase in dementia prevalence. However, the highest increase will be in the over 65's in Mid Suffolk (95%), Babergh (88%) and St Edmundsbury (83%). The lowest increase is expected in Ipswich (62%) and Waveney (by approximately 63%).⁵

Figure 43: Dementia projections (over 65's) by Suffolk LA, 2017-2035



Alzheimer’s Research UK³² suggested that the most common cause of dementia in the UK is Alzheimer’s disease, which accounts for up to two thirds of all cases. The next most common subtypes of dementia are vascular dementia, up to around 20% followed by mixed dementia. As the future population estimates for Suffolk have changed, this means that the numbers of people forecast to have each type of dementia in the future have increased, Figure 44 shows that numbers of all aged people with vascular dementia ³³are expected to double from 2015 to 2035, numbers of people with mixed dementia are expected to more than double and those with Alzheimer's expected to rise by about 90% by 2035 (8,000 to 15,100 people).

Figure 44: Dementia projections (all ages) by type of Dementia, 2015-2035



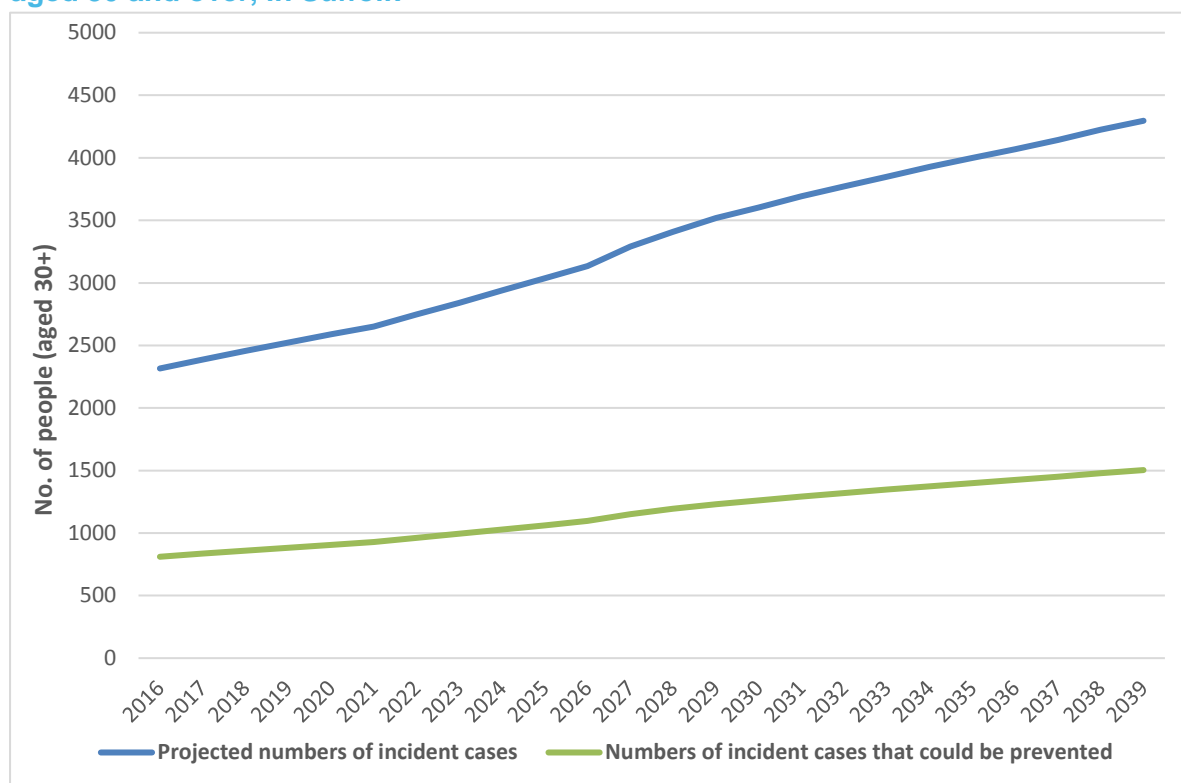
Source: Dementia Needs Assessment Refresh, 2016

5.5.3 Dementia incidence

The Global Health Data Exchange estimates the number of incident (new) cases of dementia in those aged 30 and over from 2016 to 2038. As illustrated in figure 45 below, when these figures are applied to the Suffolk population, an 85% increase (from 2316 to 4296) in new dementia cases (shown in the blue line) is anticipated from 2016 to 2038.

In 2017, two studies^{34,35} published in the Lancet Commission on dementia prevention identified a number of modifiable risk factors for dementia and further calculated the total population attributable fraction (PAF) which quantifies the contribution of a risk factor to a disease. The risk factors included in the study were: less education (none or primary school only), hypertension, obesity, hearing loss, smoking, depression, physical inactivity, social isolation, and diabetes. The total weighted PAF was found to be 35%, meaning an estimated 35% of incident dementia cases could potentially be prevented if these combined risk factors were not present. Applying these estimates to the Suffolk population aged over 30, (the green line in figure 45), shows how many of those incident cases could be prevented each year. For example, in 2018 out of the expected 2,457 new cases, 860 (35%) could potentially be prevented. It is however important to point out that preventing this number of dementia cases is unlikely to be achieved in real life as it would require elimination of the nine highly prevalent risk factors. This is therefore a hypothetical model and the numbers should be seen as speculative rather than definitive. The model however makes a valuable case for dementia prevention and highlights its importance.

Figure 45: Number of incidence cases and preventable cases of dementia in those aged 30 and over, in Suffolk



Source: Knowledge and Intelligence Team, Public Health Suffolk Analysis

5.5.4 Inequalities in dementia³¹

There are also a number of inequalities within dementia in Suffolk highlighted in the 2016 dementia needs assessment refresh:

- There is a three and a half-fold variation in the rates of dementia diagnosis between GP practices in Suffolk; this level of variation is unlikely to be explained by clinical variation alone and may be contributing to health inequalities.
- An estimated 75% of people in Suffolk with dementia live in the community and 25% live in residential care.
- It is thought that about 5,000 people may be undiagnosed. Without a diagnosis, people do not have access to therapeutic interventions and support.
- There are approximately 3,600 people over 65 years who have a learning disability in Suffolk, and this is expected to increase to 5200 by 2035. The prevalence of dementia is nearly 4 times higher among people with learning disabilities aged 65 and over compared with the general older adult population.
- It is expected that the number of people with dementia from BME groups in Suffolk is likely to increase over time. These people may have specific needs relating to vascular risk, access to services and awareness or stigma attached to the condition.
- The prevalence of dementia in the BME groups are projected to experience a seven-fold rise in comparison to a two-fold rise in the rest of the population.³⁶
- A recent systematic review suggests that there may be increased prevalence in the Black-Caribbean population, a finding which remained after controlling for socio-economic position.³⁷

5.5.5 Cost effectiveness of dementia interventions

Overall, there is a shortage of good quality evidence concerning the cost effectiveness of different interventions for dementia. It should also be noted that, although some interventions are cost-effective, there are issues with budgetary crossover which require a system-wide approach, to deal with the problem of investment being made in the health budget but leading to savings in social care. In general, the assessment of the cost effectiveness of interventions for dementia suffers from the same paucity of high-quality evidence as other aspects of research into dementia care.³¹

- National Institute of Care and Excellence (NICE) estimates that the statutory services cost saving from delaying one case of dementia for one year is £15,050, which divides approximately into 1/3 NHS costs, 1/3 local government costs and 1/3 central government costs.
- NICE suggests that up to 56% of dementia cases may be preventable due to modifiable risk factors; if only 1% of these cases could be delayed or prevented by one year, £60m of public funding would be saved per annum. Within Suffolk, this equates to 83 cases of dementia being prevented or delayed each year, reducing public spending by £1.3m per year.
- There is evidence that case management is cost effective, leading to improved quality, outcomes and delayed institutionalisation.

5.5.6 Dementia service provision

Some of the major dementia services which are being provided across the county are:

1. Since 1st of April 2017: Suffolk County Council, IESCCG and WSCCG have jointly commissioned 'Dementia Together', the new Dementia peri-/post-diagnostic support service
2. Within Suffolk both the CCGs have started an initiative to support all practices to become dementia friendly and receive accreditation. A snapshot of some of the initiatives that have been developed, accurate at the time of writing this report, include:
 - Dementia awareness sessions are offered to all staff in the CCG via the Alzheimer's Society, added to the induction programme for new staff.
 - In order to receive accreditation, all GP practices have been asked to nominate a named Dementia Champion/ Lead, complete a Kinds Fund Assessment Tool and receive Dementia awareness sessions.
 - 17 out of 24 practices in WSCCG are accredited Dementia Friendly, with the additional working towards receiving accreditation.
 - 6 out of 15 practices in WSCCG are now reaching the second year of accreditation.
 - 20 Pharmacies in Suffolk are accredited with Healthy Living Status (which requires staff to be dementia trained). The remaining are in the process as the new pharmacies Quality Payment Contracts require them to be accredited as Healthy Living Status.
 - An independently chaired, system-wide Suffolk Dementia Forum is now established.

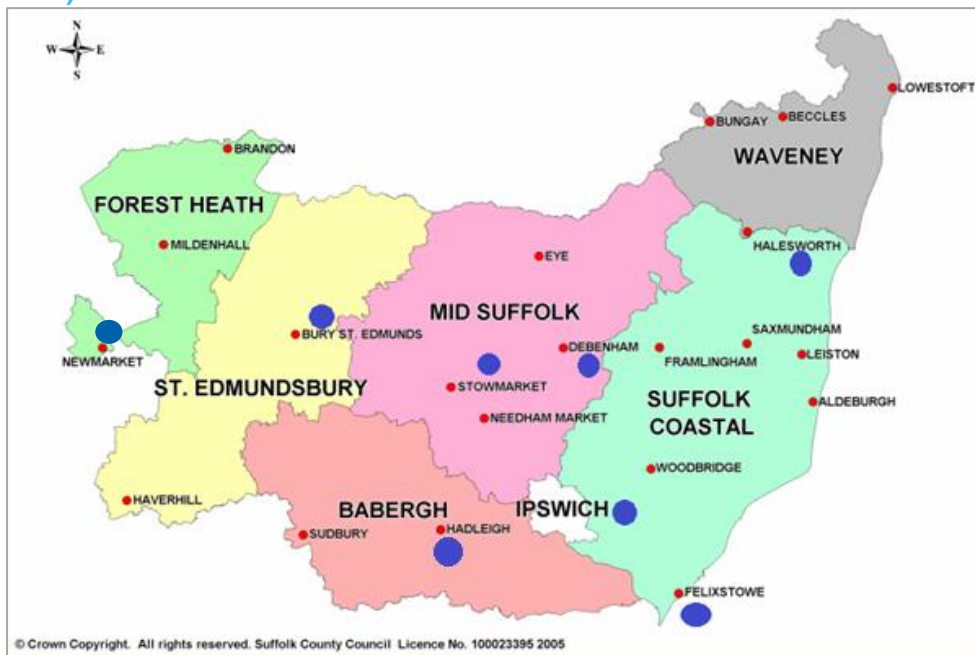
5.5.7 Dementia friendly communities

Across England, many cities, towns and villages are now exploring what they need to do to become dementia friendly; recognising the need to act and change to better support people with dementia and enable them to live well in the community.

A Dementia Friendly Community (DFC) can be described as: “A city, town or village where people with dementia are understood, respected and supported, and confident they can contribute to community life. In a dementia-friendly community people will be aware of and understand dementia, and people with dementia will feel included and involved, and have choice and control over their day-to-day lives”

Within the East of England there are 23 DFCs, out of which three are within Suffolk. Hadleigh and Stowmarket are accredited DFCs, and Ipswich was recently accredited ‘Working towards being Dementia Friendly’ status. DFCs all work closely with their Dementia Action Alliance’s (shown in blue in the map below). (Figure 46)

Figure 46: Map showing location of Suffolk’s active Dementia Action Alliances (blue dots)



Whilst there are many Dementia Action Alliances present within Suffolk (Alliances working towards making their areas more dementia friendly) the following areas are examples of best practice within Suffolk due to their demonstrable impacts.

1. **Debenham Project:** The Debenham Project is considered one of the leading DFCs within the UK. It consists of a range of local volunteer-based services, led by multidisciplinary support in the community.
2. **Hadleigh and Sudbury Dementia Action Alliance:** Hadleigh and Sudbury communities have successfully organised dementia training, raised awareness of support and are running bespoke sessions to support those with dementia, their families, and carers.

5.5.8 Age friendly cities

The World Health Organisation (WHO) has a widely accepted definition of an age friendly city (AFC). “An age-friendly city encourages active ageing by optimizing opportunities for health, participation and security in order to enhance quality of life as people age.” The WHO AFC framework has within it 8 major domains illustrated in the diagram below.³⁸ (Figure 47)

Figure 47: World Health Organisation-age friendly city and communities topic areas



Source: [http://www.who.int/ageing/publications/Global age friendly cities Guide English.pdf](http://www.who.int/ageing/publications/Global_age_friendly_cities_Guide_English.pdf)

There is also currently a global network of age-friendly cities and communities, which includes UK cities such as Manchester and Liverpool. The National Institute of Health and Research (NIHR) has funded a long running study with the primary aim to contribute to ensuring that AFC initiatives are evidence-based and evaluated. The purpose of the study is to facilitate healthy ageing and minimise health inequalities using two main principles:

1. Informed design code (i.e. ensuring age-friendliness of the built environment)
2. Exploring opportunities for research as development is progressing

As part of this work, the NIHR have developed the “Age friendly city (AFC) evaluation tool”. This is an evidence-based tool which can be used together with other assessment frameworks, e.g. the World Health Organisation (WHO) Age-Friendly Cities Guide and its accompanying checklist, to evaluate age-friendly initiatives.

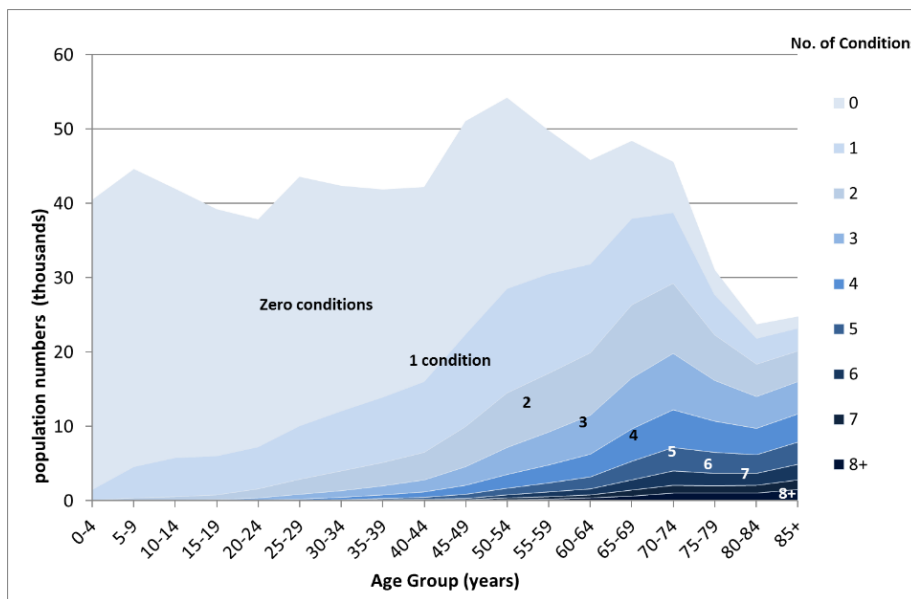
Its use has been piloted in different parts of the UK e.g. Liverpool, Sheffield and Northstowe-South Cambridgeshire. Through the work in these three sites the tool has also been fine tuned to focus on dementia friendliness and used in the DEMCOM study^{1,38}. It is a useful way of assessing local age-friendly city initiatives and can be adapted to suit different areas and local contexts. It can be used in conjunction with the WHO AFC tool to help local areas to identify strengths, gaps/weaknesses, and to monitor progress. Discussions are currently ongoing in Suffolk to explore how we could adopt the AFC approach to making Suffolk an age-friendly county.

¹ DEMCOM is a project funded by Department of Health Policy Research Programme to undertake a national evaluation of Dementia Friendly Communities from 2017 to 2019. The aim is to understand how different types of DFCs work, what is needed to sustain them and how they help different groups of people living with dementia and carers to live well.

5.6 Multimorbidities

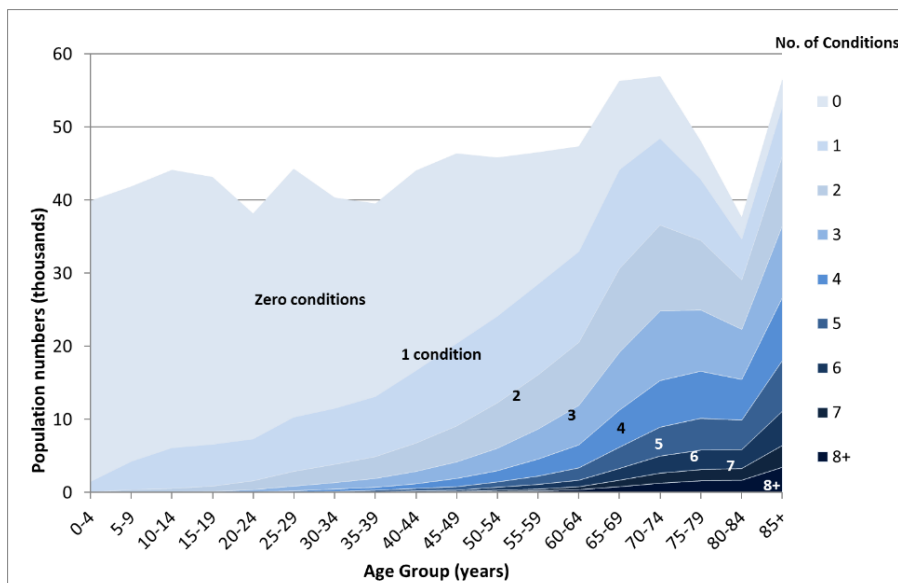
There are many people in the UK living with long-term conditions for example cardiovascular diseases, diabetes, asthma, depression etc. When an individual suffers from one or more long-term conditions, it is often referred to as comorbidity, if there are two or more conditions it is referred to as multimorbidity.³⁹ Figures from a recent national level study on multimorbidities⁴⁰ have been applied to the Suffolk population to try and understand the future impact in Suffolk and projections in terms of people with multimorbidities, it is estimated that by 2037 we will have 10 times the number of patients with 2 or more comorbidities than in 2017.⁴¹

Figure 48: Number of multimorbidities in Suffolk persons by age band, 2017



Source: Anna Crispe, Suffolk 20 years from now, Public Health Suffolk

Figure 49: Number of multimorbidities in Suffolk persons by age band, 2037



From Figures 48 and 49, it is clear that there is a changing and challenging picture presented over the next 20 years when projecting the impact of multi-morbidity in Suffolk. Although we are expecting a rise in the number of people over 65 years and then an even steeper rise in

those over the age 85, the numbers of people in these age groups that are expected to experience up to eight multi-morbidities is likely to impact on health and care services and potentially create huge strain on the Suffolk system.

A very similar pattern to Suffolk is expected for multi-morbidity in each CCG in Suffolk and Waveney (excluding Norfolk). In both the CCG areas and Waveney, between 2017 and 2037, the greatest increase in numbers (absolute change) will be in people with two or three morbidities. The greatest percentage change (relative change) will be in people with eight or more morbidities which will increase by around 60% in each CCG and Waveney. This is consistent with the findings for Suffolk as a whole from 2017 to 2037.⁴²

These projections assume no major changes in contextual conditions and treatments remain the same over the 20-year period. Multi-morbidity is a key driver for cost, which suggests that our health and care system will be unsustainable if current trends continue. It therefore highlights the need for a focus on prevention in mid-life and the need to promote healthy ageing.

5.7 Musculoskeletal (MSK) conditions

As a person gets older, the likelihood that they will experience long-term conditions and disabilities affecting the musculoskeletal system (MSK) increases. These include e.g. hip fractures, osteoporosis, arthritis and spinal conditions, and could therefore act as a barrier to productive and healthy ageing.⁴³

The rising prevalence of MSK conditions in the general population is associated with an increasing older population, reduced levels of physical activity amongst this cohort, as well as poor lifestyle habits such as smoking.

The cost to the NHS in England for treating MKS conditions per year is estimated to be about five billion pounds. MSK conditions also impact on employment prospects. In 2016 MSK problems were the second biggest cause of national workplace sickness absence. As a result, PHE recommends that interventions to prevent developing MSK conditions, which also promote ageing well, should be tailored around physical activity, maintaining a healthy weight and balanced diet, and smoking cessation.⁴⁴

5.8 Frailty

Frailty develops as a consequence of age-related decline in multiple body systems. People with frailty are vulnerable to sudden changes in their health status triggered by a seemingly minor event, for example an infection, or a fall at home. There are five broad categories for frailty syndromes, the presence of could give concerns that one has frailty. These are:

1. Falls
2. Incontinence
3. Immobility
4. Delirium
5. Susceptibility to side effects of medications

Between 25-50% of people aged over 85 are estimated to be frail. People with frailty have a substantially increased risk of falls, disability, long-term care and death. By 2037, it is expected that there could be up to 30,000 people in Suffolk living with frailty, compared to less than 15,000 people currently.⁴¹

From October 2017, GP practices were contractually required to undertake routine frailty identification and action for patients aged 65, using the electronic frailty index (eFI). A May 2018 report analysing GP Contract Services data for routine frailty identification and frailty care has benchmarked STP regions on a number of indicators as of 31st March 2018.⁴⁵ Nationally, over 2.5 million people aged over 65 had received a frailty assessment, leading to nearly one million confirmed diagnoses of either moderate or severe frailty.

Data looking at registered patients aged 65 and over in the Suffolk and North East Essex STP benchmarked against national averages/other STP areas on a number of indicators showed that:

- **35%** had a **frailty assessment** using the appropriate tool compared to the national average of 26%- ranking 7/44 (rank 1=highest).
- **12%** had a **diagnosis of moderate or severe frailty** following a frailty assessment compared to the national average of 9%-ranking 7/44.
- **73%** of had a diagnosis of severe frailty and **received a medication review** afterwards compared to the national average of 66%-ranking 7/44.
- **11%** of patients with a diagnosis of moderate or severe frailty **had a fall**, which was similar to the national average (11%) - ranking 23/44.
- **23%** of patients reported to have fallen had subsequently been **referred to a falls clinic**-compared to the national average of 25%- ranking 20/44.

Suffolk and North East Essex STP rank higher or similar to the national averages on all indicators. The development of the eFI and subsequent changes to the GP core contract could potentially provide increased recognition and understanding of frailty, however due it being such a recent development, the true impact of its implementation is yet to be determined.⁴⁵

Additionally, a 2018 UK cohort study based on 493,737 middle aged and older adults, found that frailty is significantly associated with multimorbidity in those with four or more long term conditions.⁴⁶ The top long-term conditions associated with frailty were multiple sclerosis, chronic fatigue syndrome, chronic obstructive pulmonary disease, connective tissue disease and diabetes. Frailty was also significantly associated with mortality for both men and women. The paper suggests that frailty identification and management should include middle aged individuals with frailty, thus emphasising the need for a life course approach to healthy ageing. The conditions most commonly associated with frailty could also be used to target preventive interventions.

Although there is currently no data available for Suffolk residents with delirium or susceptibility to the side effect of medications, there are limited projections for falls, incontinence and mobility provided from POPPI,⁵ all of which are based on findings from different national level studies^{47,48,49,50} which have been applied to the most recent population projection estimates. It must be noted that these numbers may be subject to inaccuracies due to survey associated bias used to calculate the estimates.

5.8.1 Falls

As people get older, the likelihood they will fall gets greater due to a number of multifactorial reasons such as long-term health conditions, dementia and frailty. According to NICE Guidelines any patient aged over 65 should be considered being 'at risk' of falling in a hospital and eligible for a multifactorial assessment⁵¹. However, a recent report by the Royal College of Physicians showed that many areas across the country have and should stop their usage

of the 'falls risk screening/prediction tools', as they fail to accurately predict the risk or harm of falling in a hospital, and also do not include an assessment for delirium (symptoms of which can increase the risk of falls). The report further states that if an effective risk assessment was developed it could not only potentially reduce length of stay, but by reducing inpatient falls by 25-30% could save the NHS £170 million a year.⁵²

Recent developments in improving falls prevention and management have included a 'Falls and fractures: consensus statement and resources pack'⁵³ published by PHE which has led to the development of the '[Falls and Fragility Fractures Pathway](#)' by NHS RightCare,⁵⁴ which highlights key interventions which should be prioritised to improve outcomes at a reduced cost. Some of the interventions include: targeted case-finding for falls risk, frailty and osteoporosis; strength and balance training; multifactorial intervention for those at higher falls risk and a fracture liaison service, with follow up at 4/12 months. Details of this are outside the scope of this report, however more information is contained in the recently refreshed "Ipswich and East and West Suffolk Falls, Fragility Fractures and Bone Health Strategy (2018-2021)".⁵⁵

Estimates and projections of falls

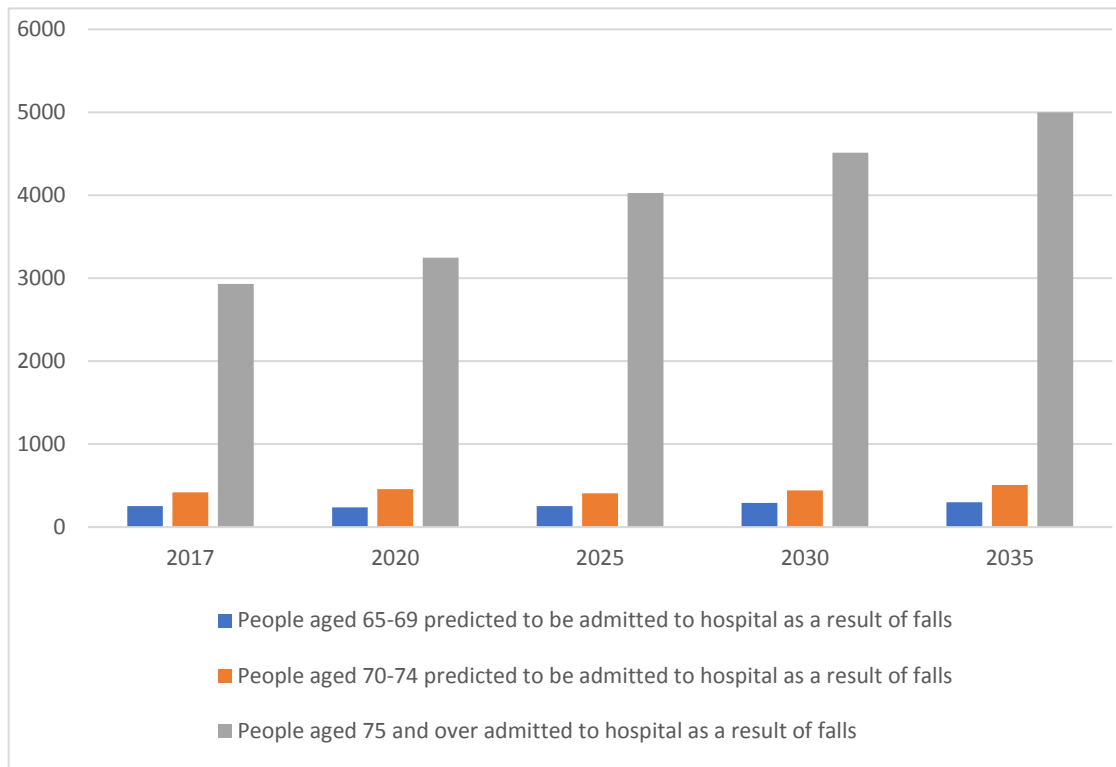
IESCCG and WSCCG have undertaken basic data analysis of the most recent falls ambulance call outs data.⁵⁶ The analysis within Ipswich and East Suffolk shows that the hotspots for ambulance call outs for falls, are in Stowmarket followed by Ipswich North and Felixstowe. A hotspot was defined by weighting ambulance call out data with population data so see which areas came out highest. When ambulance calls for falls are mapped to community health teams the hotspots are shown to be highest in Felixstowe, followed by Ipswich West, Woodbridge and Stowmarket. As expected the number of ambulance call outs for falls increases with increasing age, with the highest peak in those aged 85-89 years. This same analysis for West Suffolk shows Sudbury especially and Bury St Edmunds and Brandon are hotspots and once again the highest for those aged 75 and over (66%).

WSCCG has also carried out further analysis about West Suffolk which shows that:

- Over half of the ambulance call outs for falls resulted in a conveyance to hospital
- From 2016/17 to 2017/18 there has been an increase in falls A & E attendances of 4% across all age groups but surprisingly the highest increase has been in those aged 0-18 years.

Figure 50 shows that in Suffolk those aged 75 and over predicted to be admitted to hospital as a result of fall is much higher than the 65-74 age band. From 2017 to 2035, it is projected that there will be a 70.7% increase in the number of people aged 75 and over expected to have a hospital admission due to a fall. Further data on emergency admissions in older people due to falls is available in Section 5.9 Emergency Admissions.

Figure 50: Population aged 65 and over predicted to be admitted to hospital as a result of falls, 2017-2035, Suffolk



Source: POPPI

5.8.2 Immobility

Immobility leads to dependency, which has wider effects on the need of care, carers and care homes. To get a sense of immobility projections in the future, POPPI has included an indicator which uses responses from the Living in Britain Survey in 2001⁵⁰ to predict the number of people who will be unable to manage one mobility activity on their own by 2035. (Activities include: going out of doors and walking down the road; getting up and down stairs; getting around the house on the level; getting to the toilet; getting in and out of bed).

Figure 51: Males/Females aged 65 and over predicted to be unable to manage at least one mobility activity on their own, 2017-2035, Suffolk

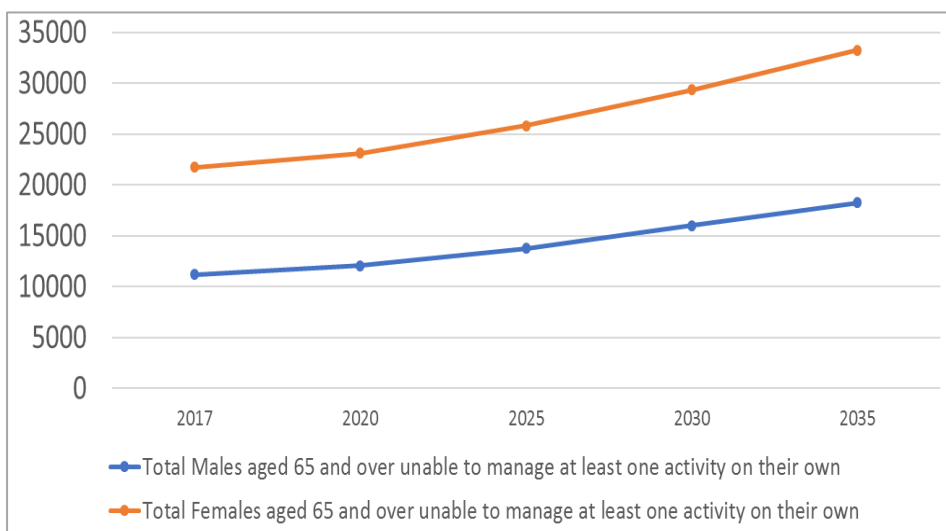
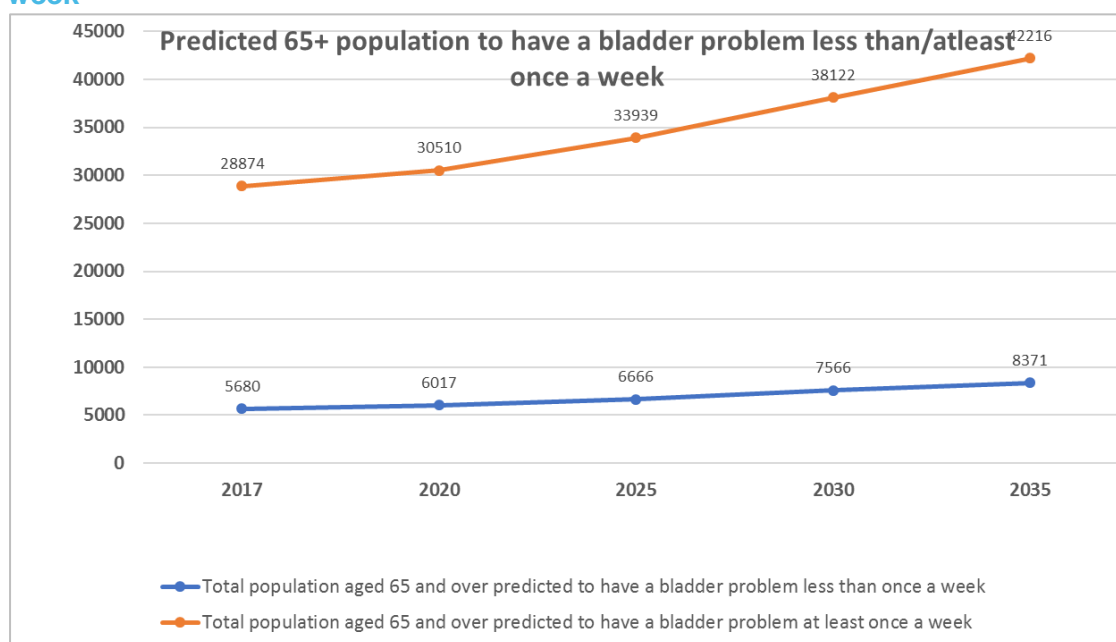


Figure 51 above shows that the number of males aged over 65 in Suffolk, who will be able to manage at least one domestic task on their own, is expected to rise by 63% from 2017 to 2035. Females over 65 over unable to manage at least one mobility related task on their own, is expected to rise by 53% by 2035. This is therefore likely to have a huge impact on the demand for care.

5.8.3 Incontinence

POPPI is also able to predict the number of people aged over 65 in Suffolk who will suffer a continence problem, by applying population projections to findings from the 2005 Health Survey of England.⁴⁸

Figure 52: Predicted 65+ population that will have a bladder problem at least once a week



Source: Projecting Older People Population Information, (POPPI)

The total population aged 65 and over predicted to have a bladder problem at least once a week is predicted to rise by an estimated 47% from 2017 to 2035 (approx. 5,680 to 8,370 and 28,870 to 42,220). (Figure 52) This also points to the rising demand for care or support in this group of people living with frailty.

While there is not a direct overlap between frailty and dementia (not everyone who is frail will have dementia, and not everyone with dementia will be frail), many people who have dementia will also be systemically frail. As services designed to proactively prevent frailty and support people with frailty develop further, there is an opportunity to use these same approaches to also identify patients with undiagnosed dementia, and to offer ongoing assessment and support to carers. Ideally, staff working in services for people with dementia should be trained in the recognition of frailty and knowledgeable about local support available in this area. Staff working in services for people who are frail should be similarly knowledgeable about effective approaches and the available local support for people with dementia.

5.9 Cancer

Nationally, nearly two thirds of cancer diagnoses occur in the over 65s and one third in people aged 75 and over. Due to advances in cancer treatment and diagnosis, there are increasingly

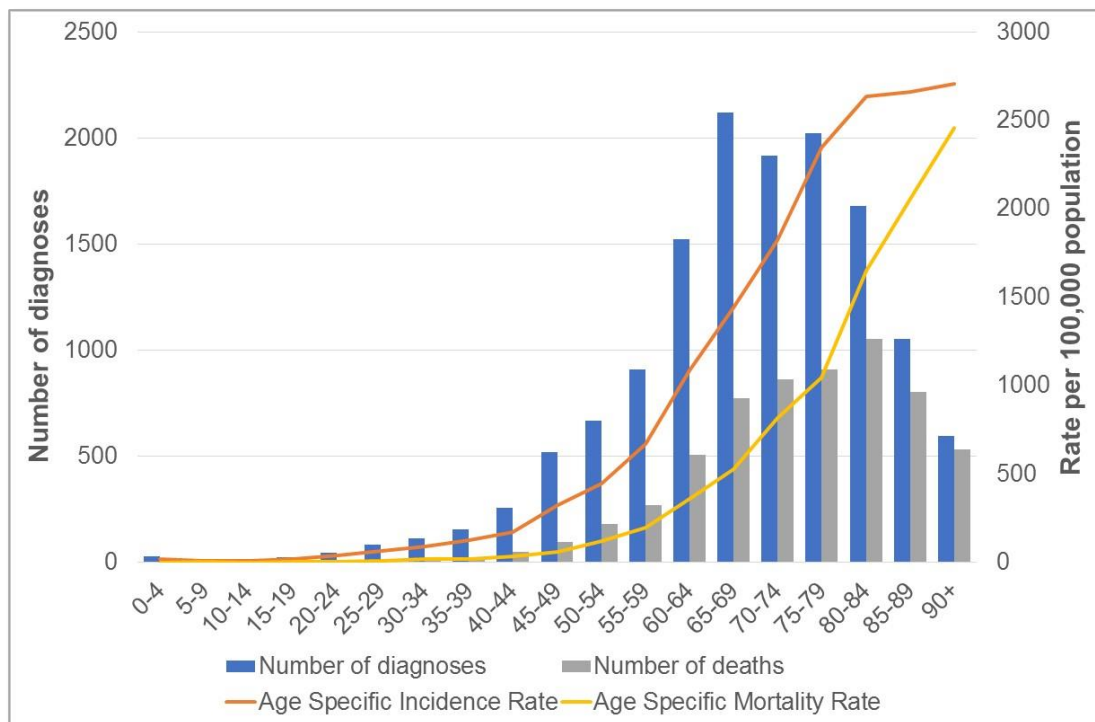
more people living with cancer aged 65 and over. The type of cancer, socio-economic status, gender and ethnicity all play a role in shaping people’s needs and outcomes. Cancer Services need to be suitable and appropriate for older people, as they are the ones most likely to utilise these services.

Cancer in Suffolk

In Suffolk, some of the top cancer diagnoses include, prostate, breast, bowel, lung, non-Hodgkin lymphoma, melanoma of skin, kidney, bladder, head and neck and pancreatic cancer. There has been an increase of 28% between 2005 (3,610) and 2014 (4,633) of new cancer cases in Suffolk. It is however estimated that four out of 10 cancers are potentially preventable; these are associated with 14 preventable causes, some of which include; ‘smoking, ‘excess weight, ‘alcohol’ and ‘sun exposure’.⁵⁷

As reflected nationally, in Suffolk older people are more likely to develop cancer with more than a third of cancer diagnoses occurring in people aged over 75 years, and the majority of deaths occur in the 75-84 years age-group.⁵⁸

Figure 53: Number of cancer diagnoses and deaths by age in Suffolk, 2012-2014



Source: Cancer in Suffolk Profile, Public Health Suffolk

Figure 53 above shows that the number of cancer diagnoses and deaths increases with age with diagnoses peaking around 65 to 79 years and deaths peaking 80 to 84 years from 2012 to 2014. However, the age specific incidence and mortality rates show a continuous increase with increasing age. Suffolk Coastal had the highest proportion of cancer diagnoses for people over 75 (43.0%) and Forest Heath had the lowest (36.3%) although this was still more than third. For Suffolk, between 2012 and 2014, 38.9% cancer *diagnoses* and 54% of cancer *deaths* occurred in people over 75. Babergh had the highest proportion of cancer diagnoses for people over 75 (57.8%) and Ipswich had the lowest (49.9%) although this was still nearly half cancer deaths in over 75s.

In terms of the (all cancers combined) 1-year survival rates for people aged 15-99 years, there has been a continuous improvement over the last 20 years for all Suffolk CCGs. In 2014, those people diagnosed with cancer, had a 1-year survival rate of 69.0% in GYWCCG, 68.2% in IESCCG and 71.8% in WSCCG.

There is a growing body of evidence which suggests that there may be inequalities in relation to older people. Evidence shows older people may be undertreated and are less likely to receive more intensive cancer therapy, such as surgery, radiotherapy and chemotherapy than younger people. Even though some older people may be less equipped to recover due to frailty, this is not true for all older people and a lack of a comprehensive assessment to test their fitness could be a reason.

What can be done?

Given that so many older people develop cancer it is important that service leaders focus on cancer prevention.

Prevention embedded across the life course can tackle multiple risk factors of cancer. Focusing on interventions to change health behaviours and increase screening coverage can prove valuable.

Lifestyle interventions, both as a preventive factor for cancer occurrence, but also for cancer survivors to prevent future recurrence can be beneficial due to the proven effects of risk reduction; stopping smoking can half the risk of cancers of the mouth, throat and oesophagus; weight management to reduce excess weight reduces the risk of developing some cancers, e.g. breast cancer; and regular physical activity interventions can reduce the risk of colon cancer by 30% and breast cancer by 20%.

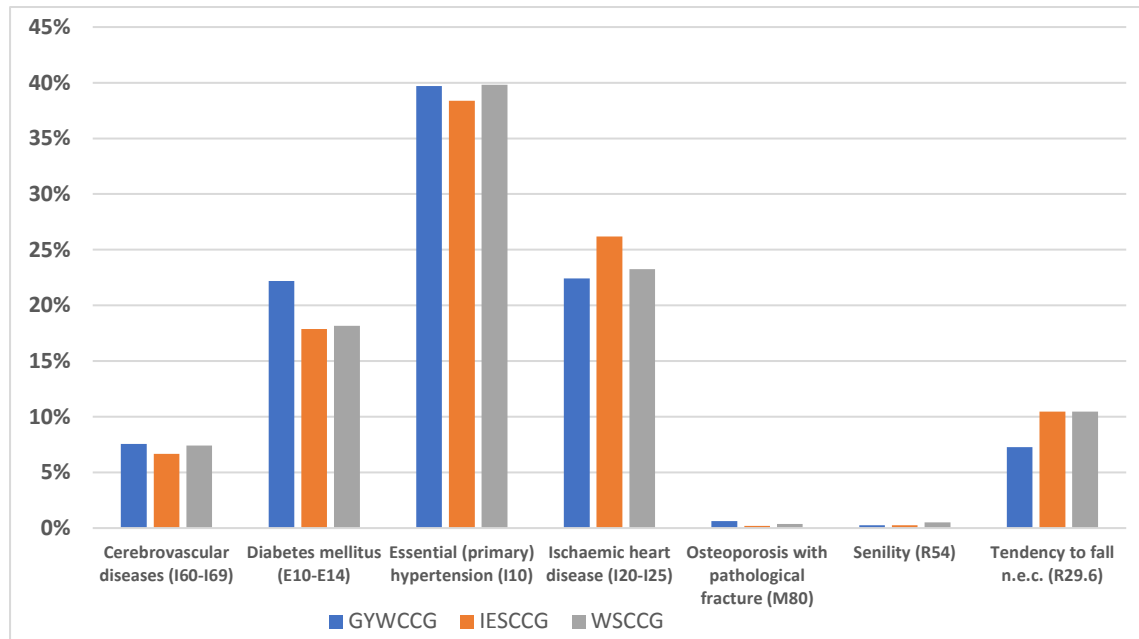
More detailed information on cancer in Suffolk can be found in the 'Cancer in Suffolk Profile' which is available on the [Healthy Suffolk website](#).⁵⁷

5.10 Emergency admissions

The rising numbers of emergency admissions in older people are concerning due to the expected increases in the older population. With an increase in those living with multi-morbidities and long-term conditions, interventions to reduce emergency admissions for older people are crucial. Emergency hospital admissions for people aged 65 and over have increased more than 45% between 2001/02 and 2012/13 nationally and similar patterns are reflected in both Suffolk CCGs. Close to half of all emergency admissions are in those aged 65 and over.

Suffolk CCG level data has been analysed from pooled data between 2014/15 and 2016/17 to provide information on emergency admissions by primary diagnosis (according to ICD-10 criteria). Seven ICD codes were selected as common diagnoses that affect older people. Data from this time period shows that for all the selected seven ICD-10 primary diagnoses analysed, hypertension was the diagnosis for which most emergency admissions occurred in the 65-84 and 85+ age groups for all CCGs. Senility (ICD-10 R54) as a diagnosis for emergency admissions appears the lowest for all CCGs in the over 65 age groups, however this could be due to this definition of senility being used less than in former years for frailty in the elderly. (Figure 54)

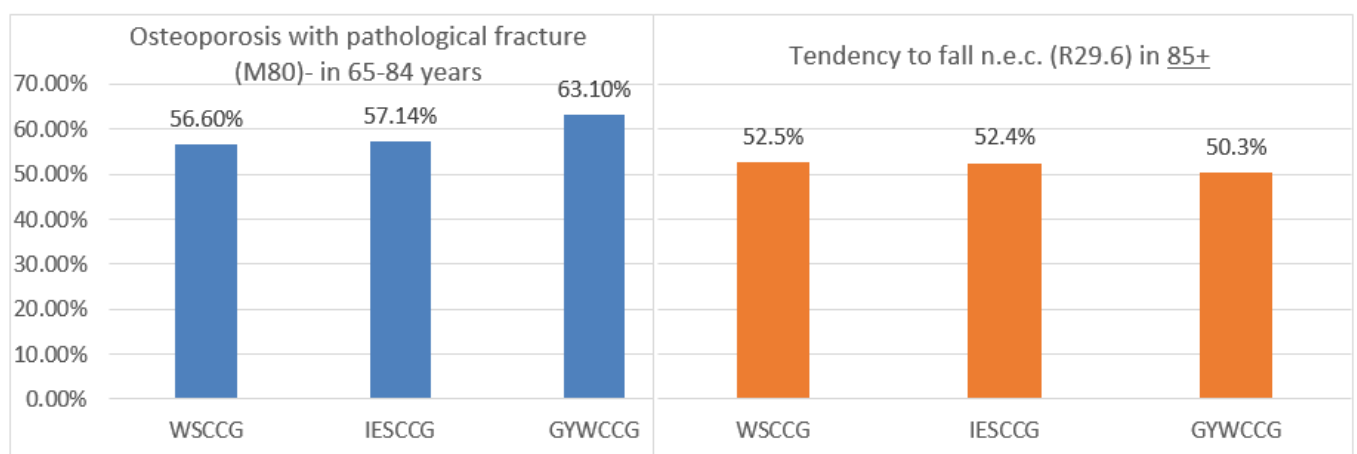
Figure 54: Emergency admissions by diagnosis (2015-2017) in 64-84-year olds



Source: Public Health Suffolk Analysis

‘Osteoporosis with a pathological fracture’ and ‘tendency to fall’ are some conditions that are associated with frailty and falls. Between 2014/15 and 2016/17, emergency admissions recorded under the diagnosis of ‘*osteoporosis with a pathological fracture*’ were most prevalent in the 65-84 age group. Figure 55 shows that 57.1% of *all* emergency admissions in WSCCG for this diagnosis, and 56.6% and 63.1% in IESCCG and GYWCCG respectively occurred in this age group. On the other hand, emergency admissions recorded under the diagnosis ‘*tendency to fall*’ were most prevalent in the 85+ age group. Approximately half of all emergency admissions under this diagnosis occurred in those aged over 85 and over across all three CCGs. (Figure 55)

Figure 55: Emergency admissions for ‘osteoporosis with a pathological fracture’ in 65-84-years olds and ‘tendency to fall’ in 85+



Source: Public Health Suffolk Analysis

5.11 Projections for future disease prevalence

Emergency admission figures give context to the predicted rise in selected disease prevalence over the next 20 years. The projections for the prevalence of selected diseases have been calculated from the Global Burden of Disease Study 2015 (GBD), which gives an estimate of the numbers of people with various diseases in Suffolk currently. Table 3 shows the percentage increase for these selected diseases (in those aged 1 and over).⁵⁹ From 2017 to 2037 the largest increase (of up to 42%) is expected in tracheal, bronchus and lung cancers. Cerebrovascular disease, COPD and ischaemic heart disease are also expected to increase by over 30% in the next 20 years. Breast cancer, falls and diabetes mellitus are all expected to increase by about 20%.

Table 3: Suffolk projections in selected diseases from 2017-2037

Disease	2017	2037	Percentage Increase from 2017 to 2037
Tracheal, bronchus and lung cancer	1,008	1,433	>42%
Cerebrovascular disease	8,429	11,566	>37%
Ischaemic heart disease	20,680	27,169	>31%
Chronic obstructive pulmonary disease	34,550	45,012	>30%
Breast cancer	7,183	9,182	>28%
Falls	50,530	64,093	>27%
Diabetes mellitus	37,586	46,610	>24%
Musculoskeletal disorders	204,410	237,729	>16%
Depressive disorders	32,472	35,667	>10%
Anxiety disorders	29,871	31,885	>7%
Drug use disorders	7,405	7,527	>2%
Migraine	105,527	107,314	>2%

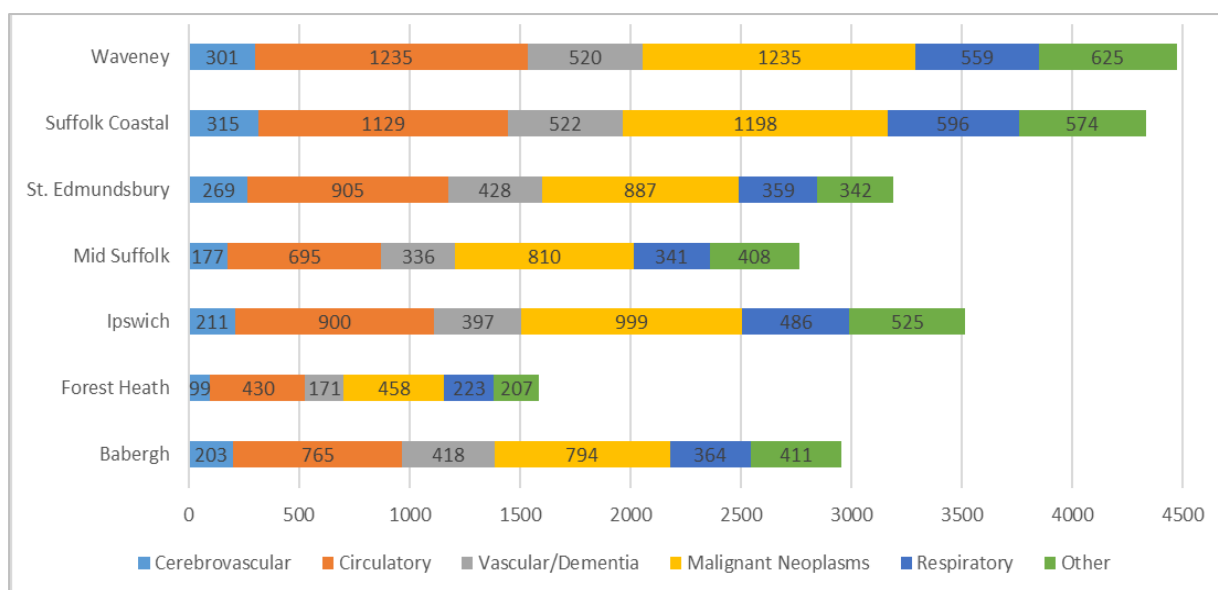
Source: Community In-Patients Bed Review-Population Projections, Public Health Suffolk

5.12 End of life

As the population is ageing, the number of those with multiple long-term conditions at the end of life is also rising. The end of life is defined as ‘any palliative care within the last 12 months of life’ by NICE. Good end of life care for older people is therefore as important a component for healthy ageing as any other and requires consideration and planning.

Public Health Suffolk undertook an analysis of deaths in Suffolk from 2014 to March 2017. Details of this is available in a separate report ‘Deaths and End of Life in Suffolk’.⁵⁹ Analysis had shown that during this time period there were around 7,600 deaths each year in Suffolk, with a split of 48% male and 52% female deaths. The leading cause of death in Suffolk as well as in all local authorities is malignant neoplasms, and diseases of the circulatory system. Figure 56 shows the number of deaths by cause and LA. It can be seen that Babergh and St Edmundsbury are the only local authorities where the number of deaths from Vascular/unspecified dementia and Alzheimer’s Disease is higher than those for diseases of the respiratory system.⁵⁹

Figure 56: Number of deaths by cause and LA, April 2014-March 2017



Source: Deaths and End of Life in Suffolk, Public Health Suffolk⁵⁹

Deaths from cerebrovascular diseases and dementia⁵⁹

During 2014 to March 2017:

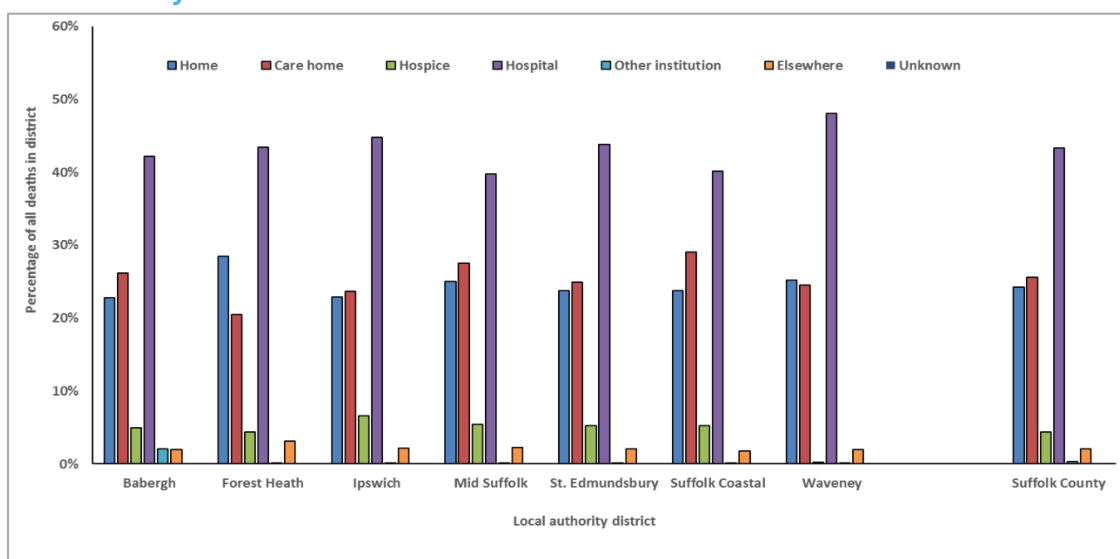
- There were 1,575 deaths in Suffolk from vascular diseases such as stroke, more than 98% of these were in those aged 65 and over.
- The higher the age band the more deaths from cerebrovascular diseases.
- Two thirds of all deaths from dementia were in females and a third in males.
- There was a 2% increase in (all age) deaths from dementia from 2014/15 to 2015/16 and a further 7% increase from 2015/16 to 2016/17.
- Suffolk Coastal and Waveney districts have seen sharper increases than other parts of the county and have the highest proportions of deaths from vascular and unspecified dementia and Alzheimer's disease (19% each) compared to other LAs

End of life in the older ages⁵⁹

- There has been an increase (between 2% and 6%) in deaths of people aged 85+ in Babergh. However, this may be due to a higher proportion of older people in that district.
- There has been a year on year increase (5% and 9%) in the number of deaths in residents aged from 65-74 in St Edmundsbury.

Place of Death

Figure 57: Percentage distribution of deaths by place of death, deaths from all causes, 2012-2014 by LA



Source: End of Life in Suffolk Report, Public Health Suffolk⁵⁹

Figure 57 above shows place of death by local authority. Some of the differences where some LAs rate higher than other LAs in the county are detailed below.⁵⁹

- Babergh has the highest proportion of deaths in other institutions (ie. prison, hostels and homes for disabled/handicapped persons).
- Forest Heath has the highest proportion of deaths at home.
- Ipswich has the highest proportion of deaths in a hospice.
- Suffolk Coastal has the highest proportion of deaths in care homes.
- Waveney has the highest proportion of deaths in hospital and very few deaths in hospice.

What can be done

Suffolk's of end of life profile shows it is vital to emphasise that the quality of care of older people at the end of life stages needs to be improved and developed further both locally and nationally.

The WHO has recently recommended a number of ways to improve palliative care for older people of which some key points include: better education of staff, educational programmes in partnerships with communities, promoting public awareness on the importance of a dignified end of life process and investment in improved palliative care in acute hospital settings, as despite opposing wishes, majority of individuals in the UK, die in a hospital.⁶⁰

Summary: Care and health conditions

Care homes:

- ❖ There has been a marked increase in A&E attendances and emergency admissions from care home residents aged over 85 in both IESCCG and WSCCG over the last two years.
- ❖ For both CCGs, the top primary diagnoses for emergency admissions and A&E attendances for care home residents was due pneumonia, UTIs and falls.
- ❖ The total over 65+ population living in a care home is expected to rise by around 90% in the next 20 years.
- ❖ In Suffolk, the number of residential care beds per 100 people aged 75 and over is lower than the regional average for residential care beds but higher than the regional average for nursing homes.
- ❖ In 2017, 22% of care homes in Suffolk were rated as inadequate or requiring improvement by the CQC impacting on capacity.

Carers:

- ❖ In Suffolk, the total population aged 65 and over providing unpaid care is currently 24,455 and is expected to rise by around 38% by 2035. Of these, those providing over 50 hours of unpaid care in 2017 was approximately 8,648 and this is expected to rise by 27% by 2035.
- ❖ The proportion of adult carers in Suffolk “who have as much social contact as they would like” is considerably lower than the English average.
- ❖ A significant number of carers (higher than national average) in Suffolk feel they “have little social contact with people and feel socially isolated”.

Dementia:

- ❖ The dementia recorded prevalence rate (in those aged 65 and over) is 4% in Suffolk.
- ❖ WSCCG has a significantly lower 65+ dementia diagnosis rate (61.9%) than the national average (67.9%).
- ❖ There is a three and a half-fold variation in the dementia diagnosis rates between GP practices in Suffolk; this level of variation is unlikely to be explained by clinical variation alone and may be contributing to health inequalities.
- ❖ The prevalence of dementia is nearly 4 times higher among people with learning disabilities aged 65 and over compared with the general older adult population.
- ❖ Forecasts indicate there will be nearly two and a half times the number of people aged 85+ with dementia by 2035 compared to 2015.
- ❖ Marked increases in dementia prevalence is expected in all Suffolk local authorities, but the highest increases are expected in the over 65's in Mid Suffolk.
- ❖ The prevalence of dementia in the BME groups are projected to experience a seven-fold rise in comparison to a two-fold rise in the rest of the population.
- ❖ Suffolk has many Dementia Action Alliances. Examples of best practice include the “Debenham Project” and the “Hadleigh and Sudbury Dementia Action Alliance”.
- ❖ Age-friendly cities encourage active ageing by optimizing opportunities for health, participation and security in order to enhance quality of life as people age. Discussions are currently ongoing to explore how we could adopt the AFC approach to making Suffolk an age-friendly county.

Multimorbidities:

- ❖ In 2037 we will have approximately 10 times the number of patients with 2 or more comorbidities than in 2017.
- ❖ Multimorbidity is a key driver for cost, which suggests that our health and care system will be unsustainable if current trends continue. A focus on prevention in mid-life and the need to promote healthy ageing is therefore crucial.

Frailty:

- ❖ The number of people living with frailty in Suffolk is expected to double in the next 20 years.
- ❖ The *electronic Frailty Index (eFI)* is being used in general practice for routine frailty identification and action. Its use could potentially improve the detection and management of frailty. Analysis of this data shows that nationally, over 2.5 million people aged over 65 have now received a frailty assessment, and one million people received a confirmed diagnosis of moderate or severe frailty.
- ❖ Evidence suggests that in middle aged and older adults, frailty is significantly associated with multimorbidity in those with four or more long term conditions. Long-term conditions associated with frailty include multiple sclerosis, chronic fatigue syndrome, chronic obstructive pulmonary disease, connective tissue disease and diabetes. These findings should be considered the development of frailty management pathways.
- ❖ From 2017 to 2035, the number of people aged 75 over admitted to hospital due to a fall is expected to rise by 70%.
- ❖ The older population with immobility, incontinence and self-care limitations is predicted to rise significantly.

Health conditions:

- ❖ Diseases where we expect to see the highest increase in prevalence over the next 20 years are cancers, cerebrovascular disease, COPD, IHD, falls and diabetes.
- ❖ In Suffolk, older people are more likely to develop cancer, with more than a third of cancer diagnoses and more than half of cancer deaths occurring in people aged over 75 years.
- ❖ More people aged 65 and over are living with or surviving cancer. Cancer services therefore need to be suitable and appropriate for older people.
- ❖ Evidence suggests that older people may be undertreated and are less likely to receive more intensive cancer therapy than younger people.
- ❖ Prevention embedded across the life course can reduce the risk of developing cancer. Lifestyle interventions are both useful not only in preventing cancer occurring but also in preventing recurrence in cancer survivors.
- ❖ The prevalence of MSK conditions has increased with an ageing population, also due to reduced physical activity as well as poor lifestyle habits such as smoking. Interventions to prevent MSK conditions also promote ageing well and should be tailored around physical activity, maintaining a healthy weight and balanced diet, and smoking cessation.
- ❖ Emergency hospital admissions for people aged 65 and over have increased nationally and locally. Close to half of all emergency admissions are in those aged 65 and over.
- ❖ Good end of life care for older people is an important part of healthy ageing and requires

6. SOCIOECONOMIC AND ENVIRONMENTAL CONDITIONS

Case Study: Chester-100 years old



Chester is 100 years old. He lives in Worcestershire and although not from Suffolk, he is an example of someone who is ageing well, that any individual can and should feel inspired by. Here is Chester's healthy ageing story.

Chester volunteers seven hours a week at his local food bank: He says:

"I don't feel 100 usually but my body tells me I am not as young as I used to be"

"I do what I can, and when I can't I sit down."

"I take every day as it comes and I'm really grateful that I can look after myself and am not a burden on anyone else."

Chester's Colleagues say:

"He brings joy to us every time he comes in and he's an example to us all - that we should do everything, every day and make the most of it, no matter what age"

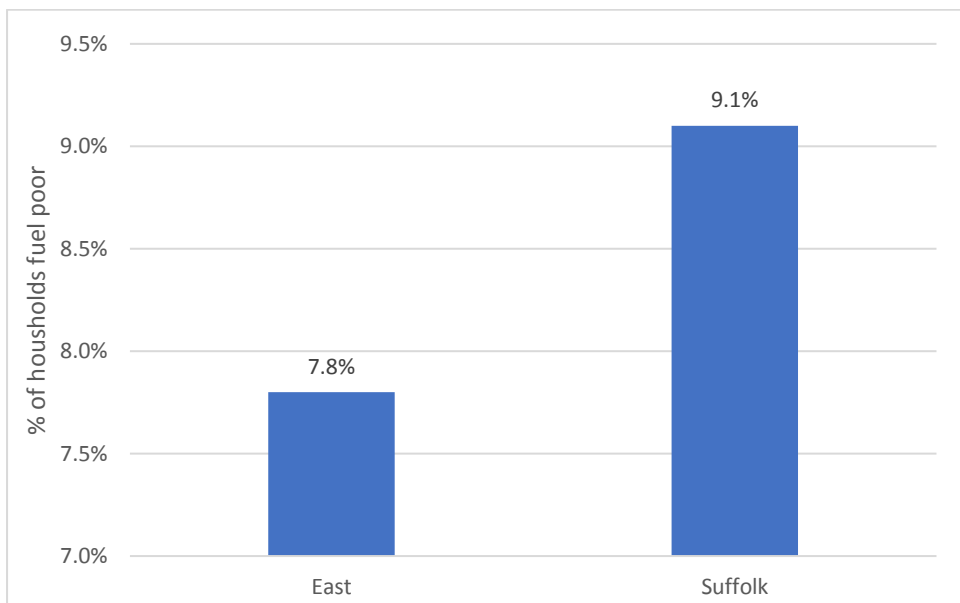
Source: <http://www.bbc.co.uk/news/av/uk-england-hereford-worcester-39555472/the-100-year-old-volunteer-taking-every-day-as-it-comes>

6.1 Fuel poverty

A fuel poor household is defined by the Low Income High Costs (LIHC) Indicator as a household which needs to spend more than 10% of its income on all fuel use and were they to spend that much, their remaining income would put them below the poverty line.⁶¹ There are currently around 2.4 million households and 1.14 million older people in England living in fuel poverty. Fuel poverty is closely associated with cold homes. Older people on average spend more time in their homes and may be living on low income which may act as a barrier to heating their homes adequately. The harmful health effects that arise from living in a cold home are well known ranging from chronic illness, reduced mobility, a poorer quality of life, to falls and depression.

Data from the Department of Business, Energy and Industrial Strategy shows that overall the rate of fuel poverty in Suffolk has dropped from 11.4% in 2011 to 9.1% in 2015. However, the proportion of household's fuel poor in Suffolk is considerably high at 9.1% (29,306 households) compared to the East of England average of 7.8%. (Figure 58)

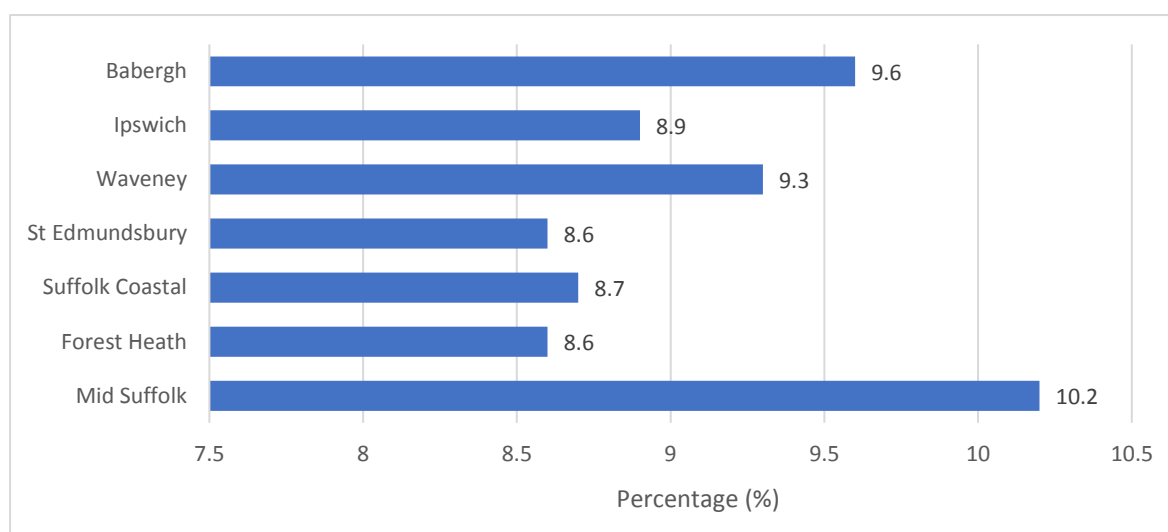
Figure 58: Proportion of fuel poor households in Suffolk and East of England



Source: Department of Business, Energy and Industrial Strategy

There is large variation between Suffolk local authorities. St Edmundsbury, Forest Heath and Suffolk Coastal have the lowest proportion of household's fuel poor at approximately 8.6%. On the other hand, Mid Suffolk has the highest proportion of household's classed as fuel poor at 10.2%, followed by Babergh and Waveney at 9.6% and 9.3% respectively (Figure 59). All Suffolk local authorities have the proportion of fuel poor households higher than the regional average, which raises concern that this is a notable issue for Suffolk. Given the impact living in a cold home has on health and wellbeing, action is required across the county to improve Suffolk's housing stock.

Figure 59: Proportion of household's fuel poor in Suffolk local authorities



Source: Department of Business, Energy and Industrial Strategy

6.2 Excess winter mortality

Excess winter mortality is defined as the difference between the number of deaths which occurred in the winter months (December to March) and the average number of deaths during the preceding four months (August to November) and the subsequent four months (April to July). Higher mortality is seen in the winter months, and most commonly during the December to January period.⁶²

Excess winter mortality is associated with fuel poverty. An estimated 10% of excess winter deaths may be directly attributable to fuel poverty.⁶³ Another risk factor for excess winter mortality is housing conditions, which can affect both the coldest and warmest of homes. For every one-degree Celsius drop in the outside temperature, for those living in the 10% of coldest of homes the mortality rate rises about 2.8%, whereas there is a 0.9% rise in mortality rate for every one degree rise in temperature for the warmest of homes. Older people are more vulnerable to the cold, and respiratory and cardiovascular problems that are associated with winter temperatures can lead to a higher mortality in winter months. Therefore, winter weather has a direct effect on the incidence of heart attack, stroke, respiratory disease, flu, falls and injuries and hypothermia, and can lead to excess winter mortality.⁶⁴

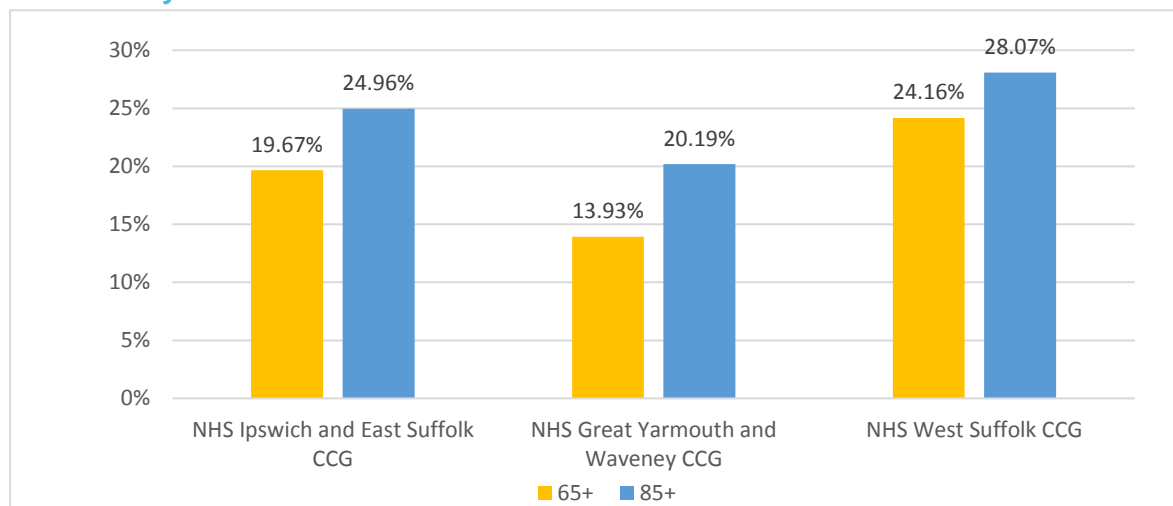
National data from 2015 appears to show that excess winter deaths are almost 3 times higher in the coldest 25% of homes compared to the warmest 25%, and mostly occur among people aged over 75. It is estimated that 40% of excess winter deaths are attributable to cardiovascular disease; and 33% to respiratory disease.⁶²

To provide a Suffolk picture of excess winter deaths (EWD), data has been analysed from the period of August 2011 to July 2016, and is represented as Excess Winter Deaths Index (EWDI) in order to make comparisons between sexes, age groups and regions.⁶²

EWDI is calculated by first calculating the EWD (winter deaths - average non-winter deaths). Then this EWD is divided by the non-winter deaths as follows- ((EWD/non-winter deaths X100)) to give a percentage of extra deaths that occurred in the winter

Figure 60 below shows the pooled EWDI from August 2011 to July 2016, for those aged 65+ and 85+ by CCG. As expected, in all three CCGs, those aged 85 and over have a higher EWDI compared to those aged 65 and over. WSCCG's EWDI for those aged over 65, is 24.2% followed by IESCCG at 19.7% and finally 14.0% for GWCCG. This same pattern is reflected for those aged 85 and over, where WSCCG has the highest EWDI (28.1%) and GYWCCG has the lowest (20.2%) while IESCCG has EWDI of 25.0%.

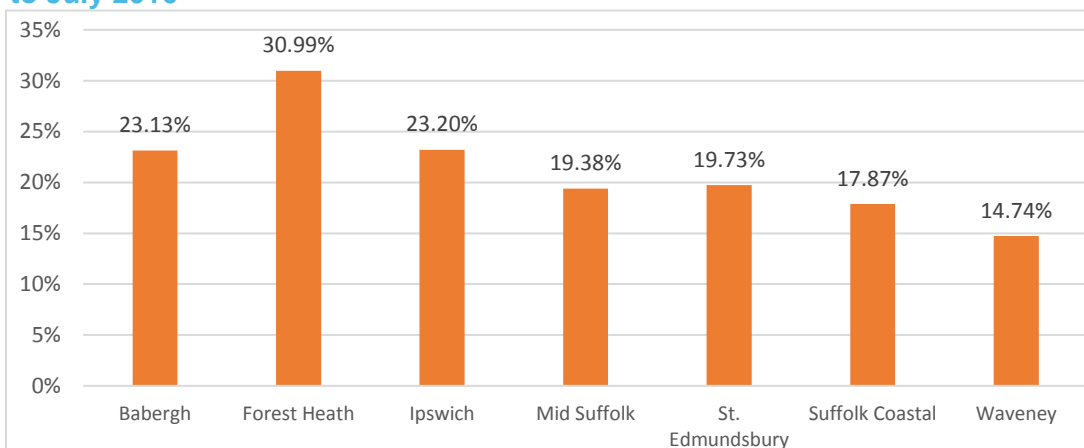
Figure 60: Excess Winter Death Index for people aged 65+ and 85+ by CCG, August 2011 to July 2016



Source: Stephen Patterson, Public Health Suffolk Analysis

Figure 61 shows EWDI by LA. Forest Heath has the highest EWDI for those aged 65 and over at 31% and Waveney with the lowest at 14.7%. Interestingly, the findings from the analysis of fuel poverty indicate that Forest Heath has the lowest proportion of household's fuel poor. As earlier noted, fuel poverty is thought to be responsible for 10% of EWD, so other factors are likely to be driving the EWD in Forest Heath.

Figure 61: Excess Winter Death Index for people aged 65+ and 85+ by LA, August 2011 to July 2016



Source: Stephen Patterson, Public Health Suffolk Analysis

The '[Suffolk Housing and Health Needs Assessment](#)'⁶⁵ found that in the 10 year period between 2005/6-2013/14 an estimated 123 deaths per year (median 110) were due to cold homes.⁶⁵ Furthermore a study conducted to measure the effect of colder winters on hospital admissions in Suffolk from 2003 to 2013 showed that the overall hospital admission rates for all ages were raised by 2%, and emergency admissions raised by 5% during cold winters. Whilst these figures cannot be explained by cold homes alone, it can be assumed that it is a contributing factor for which a number of these admissions could be avoided.⁶⁶

6.3 Housing and health

In Suffolk the number of older people living in their own homes is high, however whether those homes are fit and equipped for an ageing population is another matter. The table below shows that the 80.1% of those aged 65-74 currently own their house while 7.1% in this age group rent from the council. About 68% of those aged 85+ own their house while 68% rent from the council and 11.5% live in socially rented property.

Table 4: Tenure by age group

	People aged 65-74	People aged 75-84	People aged 85 and over
Owned	80.1%	77.0%	68.1%
Rented from council	7.1%	9.1%	11.6%
Other social rented	6.0%	7.6%	11.5%
Private rented or living rent free	6.8%	6.4%	8.85%

Source: POPPI

An overview of Suffolk's housing profile can be found from the English Housing Survey (HHSRS). The 2015 Survey⁶⁷ shows that 9.3% of properties from pre-1919 are estimated to exhibit excess cold and 0.4% for those properties built after 1990. Properties in rural areas have the highest levels of excess cold. Levels of excess cold is also associated with tenure. Excess cold is highest in private rented accommodation (4.8%) compared to owned houses (3.35) and social rented housing (0.5%).

What should be done

Research previously suggested there may be a retirement housing gap of 160,000 homes nationally by 2030. If current trends continue, this gap will more than double by 2050.⁶⁸ With larger cohorts of older people expected in Suffolk, more vulnerable people are at risk of the severe health impacts of unsafe, unhealthy and unsuitable homes. The '[Suffolk Housing and Health Needs Assessment](#)' provides a more detailed analysis of housing needs and makes recommendations for key areas of development. Some of these include considering how partners can work together more efficiently to advise to older people about heating, to prevent condensation/damp/mould and developing more resources in order for older people to access housing support and report poor housing conditions more easily.

Furthermore, recent reports suggest that those older people who require specialist housing (defined as sheltered, extra care, residential care, or nursing care), currently have difficulties accessing this housing provision, and that some of this provision may no longer be fit for purpose. The needs assessment highlights the growing need to ensure that older people have

access to appropriate and affordable housing options that meets the requirements of additional needs older people may have.

6.4 Healthy ageing economy

The current demographic changes have resulted in the government announcing changes to the State pension age. This will increase for both men and women to 66 between 2018 and 2020 and even further to 68 between 2044 and 2046. Despite this, vast numbers of people are leaving work prematurely. The average number of years spent in work has showed only minor increases since 1990 and people are leaving work much earlier than in 1950. About 70% of people aged 50-64 are in work, compared to 83% of people aged 25-49 and less than half of people are still in work the year before they reach State pension age.^{69,70}

However, older people are a huge source of skills, and offering opportunities to keep them in work, in any shape of form, is a huge benefit for UK growth. Working later in life benefits individuals by keeping them socially connected and financially secure. In turn, society benefits from the economic contributions of those over 65, which will reach an estimated £82 billion nationally by 2030.⁷¹

Interventions to promote older people as well as the younger generation to remain in work for longer, can have notable effects on ageing well. Studies have shown that maintaining a purpose in life helps retain physical function amongst older adults.⁷² Qualitative research has shown that older people want to stay in work for longer, as they feel a sense of empowerment and positive contribution to society. However, to achieve this, it is essential that work places adapt working styles and opportunities to suit the needs of an older person.

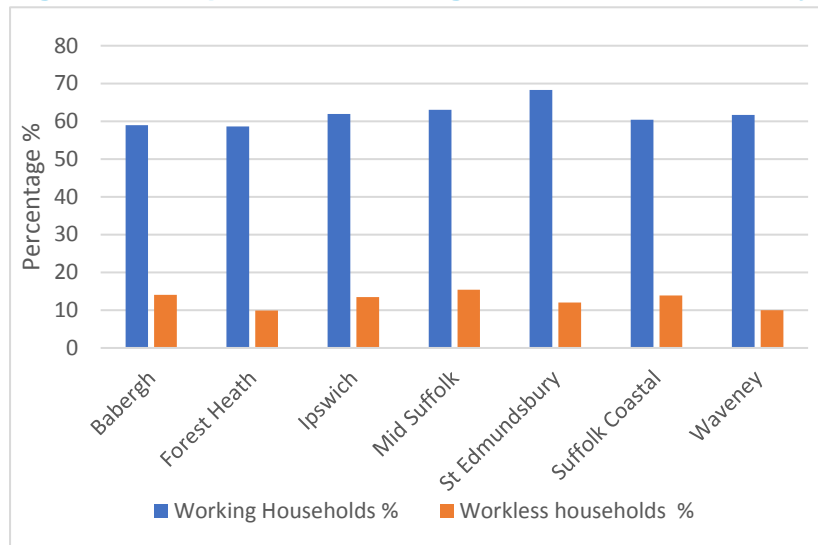
NOMIS (official labour market statistics)⁷³ is able to provide the most up to date labour market statistics, at a regional, county or local authority level depending on the indicator chosen. The site uses multiple sources of data including the Census 2011, Department of Work and Pensions (DWP) and Annual Population Survey. An analysis of NOMIS data on the following indicators is presented next.

- Households and unemployment
- Employment rate
- Unemployment rate
- Economic activity
- Carers allowance
- Disability allowance
- State pensions
- Income support

Households and employment

According to ONS, a working household is where all members above 16 years are employed. A workless household is where no one aged above 16 years is employed (either unemployed or economically inactive). Figure 62 shows that St Edmundsbury has the highest percentage of working households (68.3%) and Forest Heath has the lowest (58.6%). Mid Suffolk has the highest percentage of workless households (15.5%) and Forest Heath has the lowest proportion (9.9%).

Figure 62: Proportion of working/workless households by LA, 2015



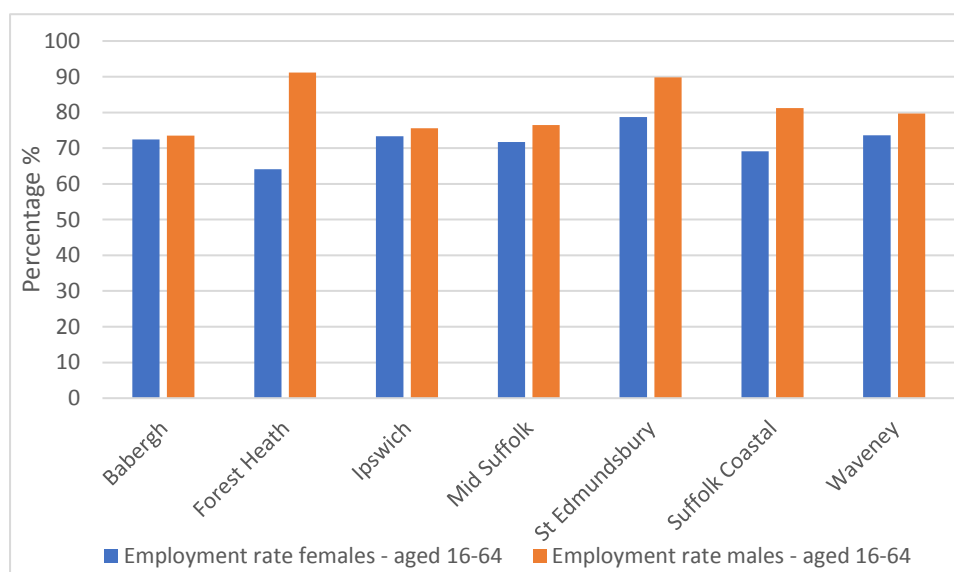
Source: NOMIS

Employment rate

In 2016/17, Suffolk had an employment rate in those aged 16-64 of 77.0% compared to the national average of 74.7%. In 2015/16, overall, there were more males than females in employment. The highest male employment rate was in Forest Heath at 91.2%, followed by St Edmundsbury at 89.8%. The lowest male employment rate was in Babergh at 73.5%. (Figure 63 below)

For females aged 16-64 the highest employment rate of 78.7% was in St Edmundsbury, followed by Waveney at 73.6%. The lowest female employment rate in this age group was in Forest Heath at 64.1%. Forest Heath also shows the largest gap in male and female (16-64) employment rate with males having a 27.1% higher rate than females.

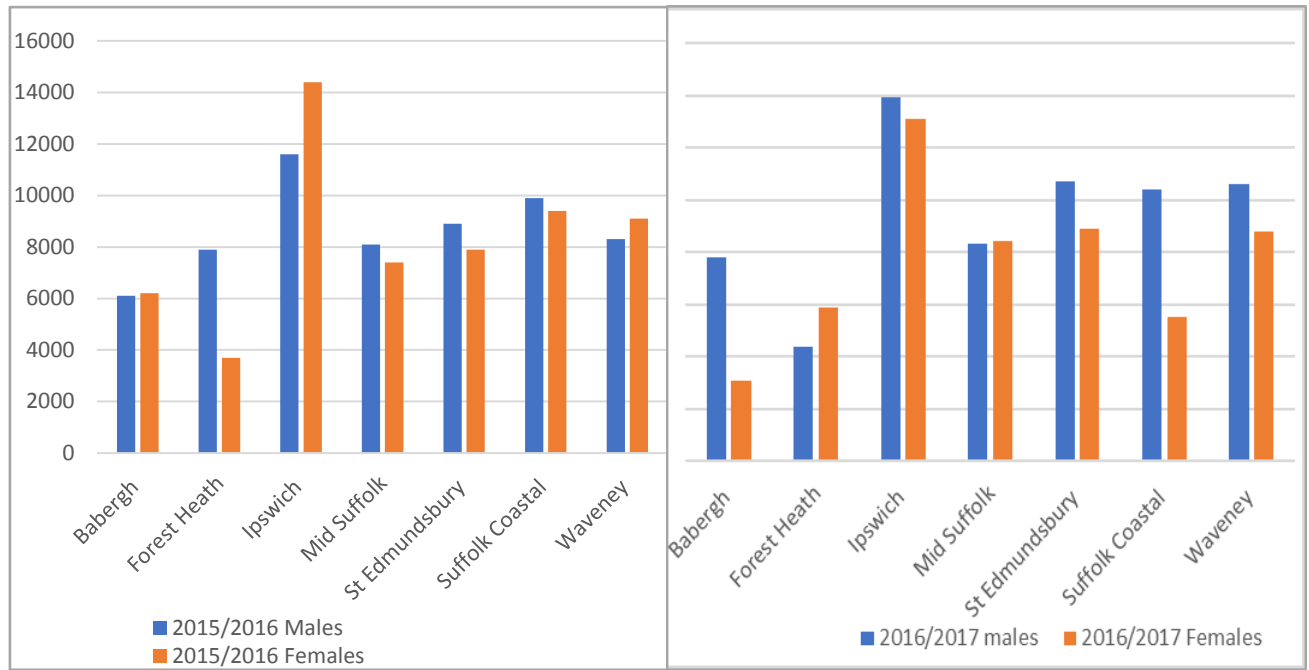
Figure 63: Employment rate (aged 16-64) by LA and gender, 2015/16



Source: NOMIS

Between 2015/16 and 2016/17 the number of those aged 50 and over and in employment was highest in Ipswich for both genders and lowest in Babergh and Forest Heath. (Figure 67). For all districts, the number of males aged over 50 and in employment increased during this period. Suffolk Coastal, Babergh, Waveney and Ipswich however saw a reduction in the number of females aged over 50 and in employment.

Figure 67: No. of persons aged 50+ employed from 2015/16 to 2016/17, by LA

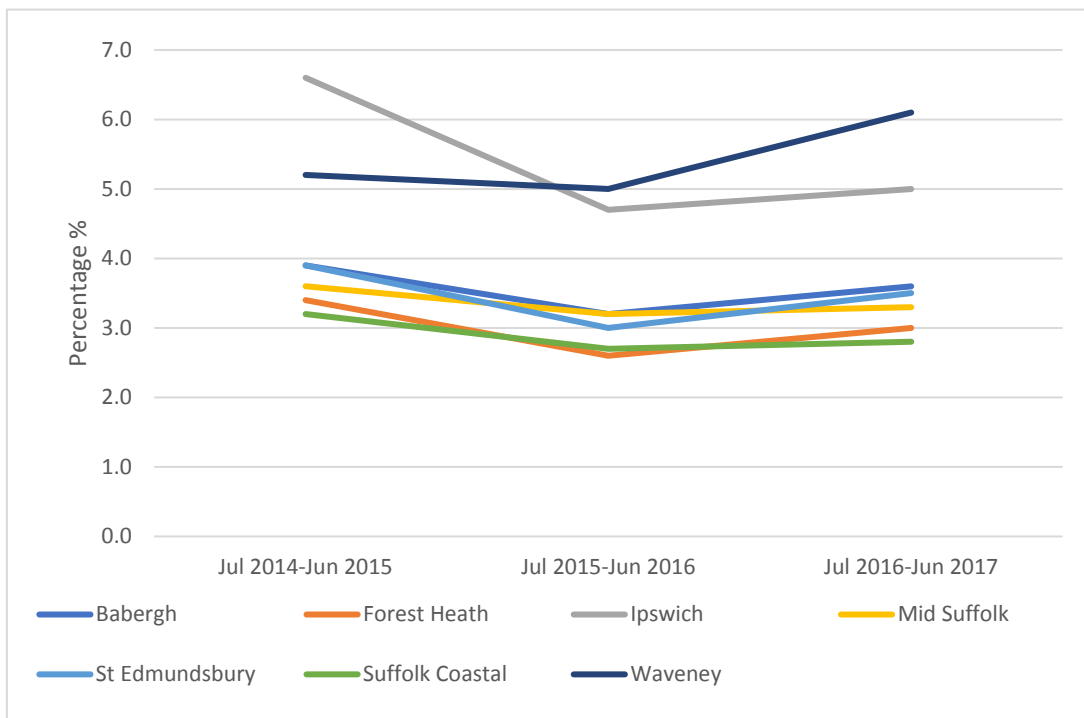


Source: NOMIS

Unemployment rate

The unemployment rate is the unemployment count as a percentage of the economically active population aged 16+. Model based estimates of unemployment based on the Annual Population Survey shows that overall, Suffolk had an unemployment rate of 3.9% in June 2016/July 2017. The unemployment rate however varies across local authorities. For all local authorities the unemployment rate decreased between June 2014/July 2015 and June 2015/July 2016 then rose again in the coming year (Figure 68). Ipswich and Waveney had much higher unemployment rates than the rest of Suffolk. In June 2014/July 2015, Ipswich had the highest unemployment rate. This decreased until June 2015/July 2016, as the unemployment generally fell across Suffolk. However, Waveney saw a much smaller fall and by June 2015/July 2016, it had the highest unemployment rate, estimated at 5% and at 6.1% in June 2016/July 2017. It is worth noting that Waveney had the greatest increase (1.1%) in unemployment rate between June 2015/July 2016 to June 2016/July 2017.

Figure 68: Unemployment rate (16+) 2014/2015-2016/17, by LA

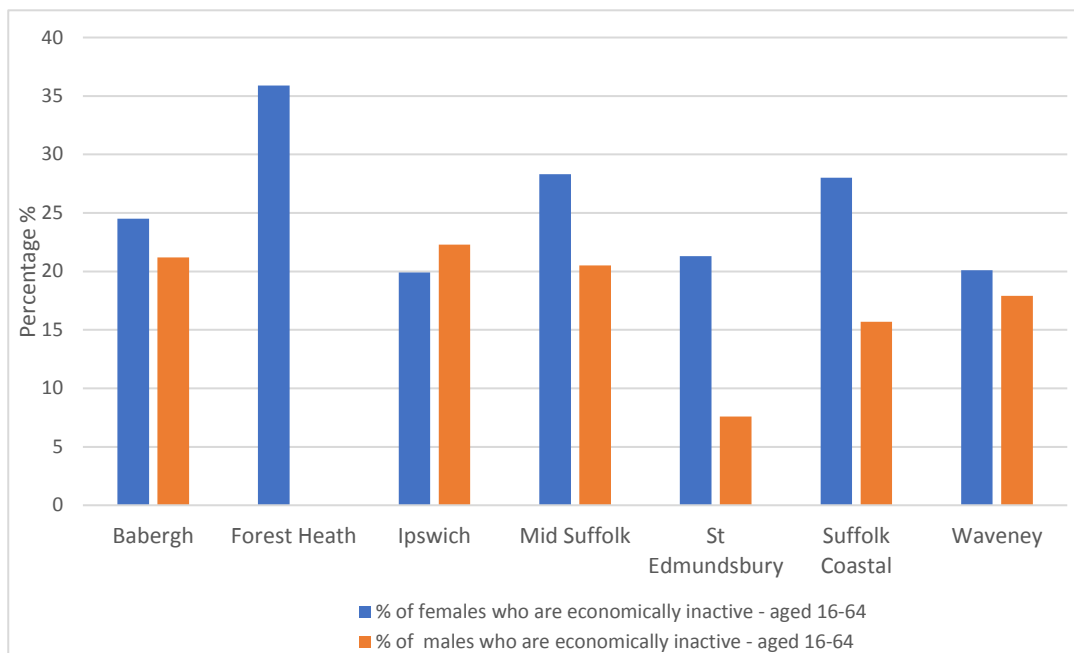


Source: NOMIS

Economic inactivity

The term “economic inactivity” is used to describe a situation where an individual is not in employment and has not been seeking work within the last 4 weeks and/or are unable to start work within the next 2 weeks. It includes students, the long-term sick, unpaid carers and those who retire early⁷³. Figure 69 below shows females (aged 16-64) are more economically inactive compared to males in Suffolk. Forest Heath has the highest percentage of females who are economically inactive at 35.9%, whereas Ipswich females have the lowest (9.9%). Data for males in Forest Heath is unavailable; however, Ipswich has the highest percentage of economically inactive males (22.3%) and St Edmundsbury has the lowest (7.6%). Males and females in St Edmundsbury have the largest difference (of 13.7%) in rates of economic inactivity.

Figure 69: Proportion of persons (16-64) economically inactive by LA and gender

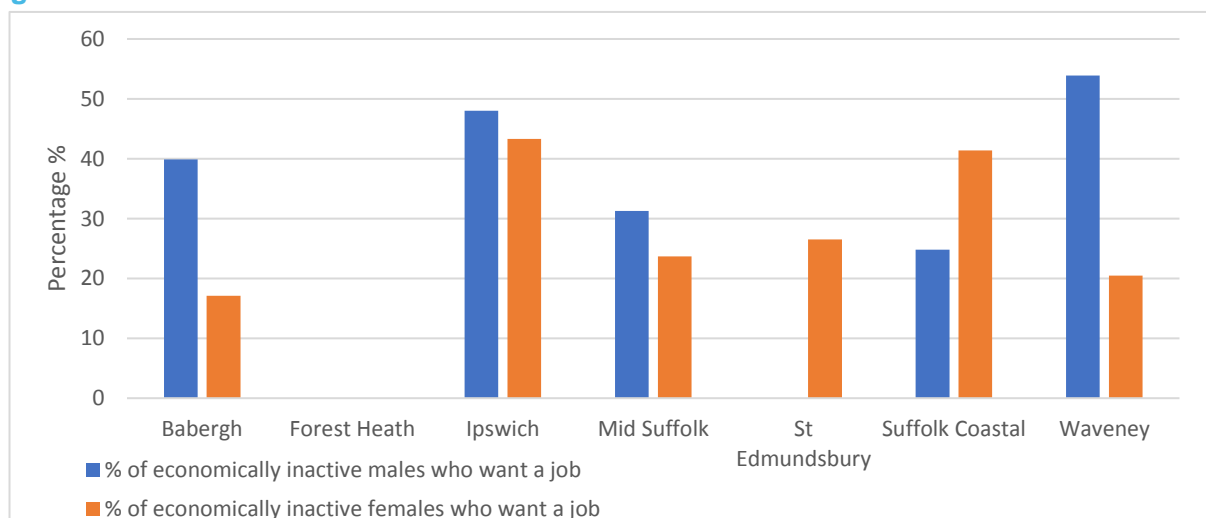


Source: NOMIS

The Annual Population Survey also contains data on whether this cohort of economically inactive persons are interested in getting a job. It must be noted that data from some areas was unavailable due to low response rates.

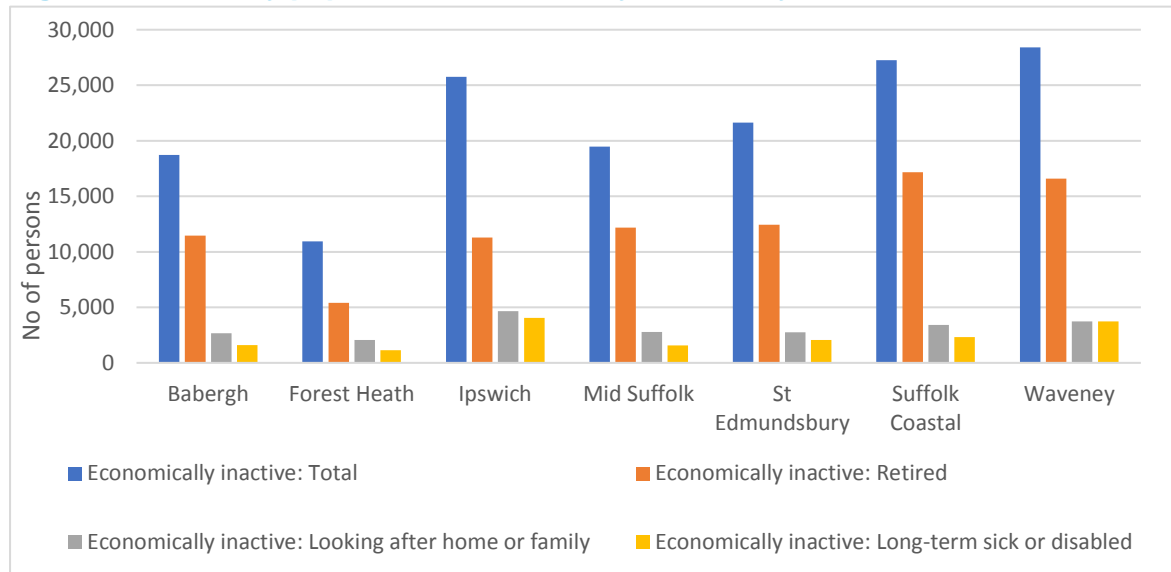
Waveney had the highest number of economically inactive males who reported that they wanted job at 53.9% while Suffolk Coastal had the lowest at 24.8%. Ipswich had the highest percentage of economically inactive females who wanted a job at 43.3% while Babergh had the lowest at 17.1% (Figure 70). Please note, for some areas in this category including Forest Heath data are not available due to very low response rates to the survey.

Figure 70: Proportion of population economically inactive who want a job, by LA and gender



Source: NOMIS

Figure 71: Workday population economically inactive by reason and LA, Census 2011

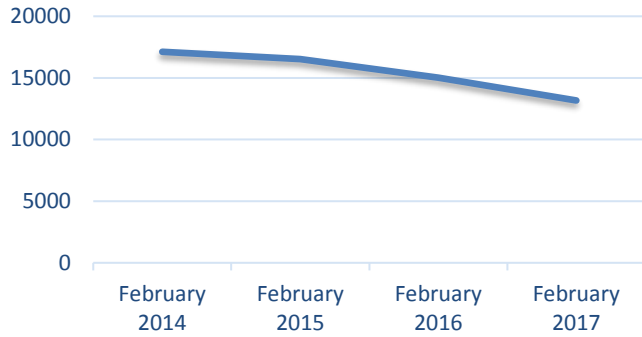


Source: NOMIS

As mentioned above there are number of reasons why some of the population is economically inactive. Figure 71 presents data from the 2011 census which shows that Suffolk Coastal has the highest number of persons who are economically inactive due to being retired. Ipswich (followed by Waveney) has the highest proportion of individuals classed as economically inactive population because they are “looking after a home or family” as well as due to long-term sick or disabled.

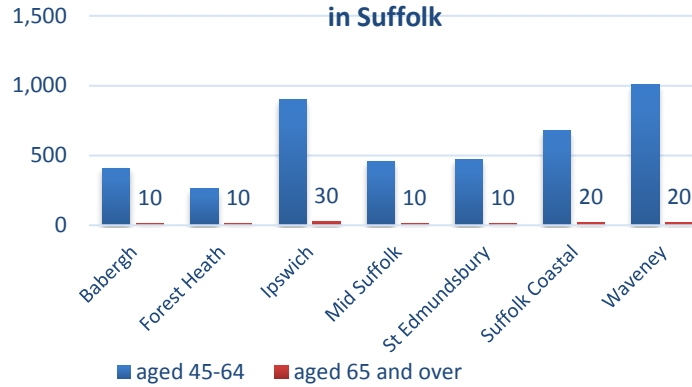
The next page contains a snapshot of Suffolk’s residents receiving benefits payments in the form of a Disability Living Allowance, Carers Allowance, Income Support and State pension.

No. of over 50's in Suffolk claiming Disability Living Allowance from 2014 to 2017



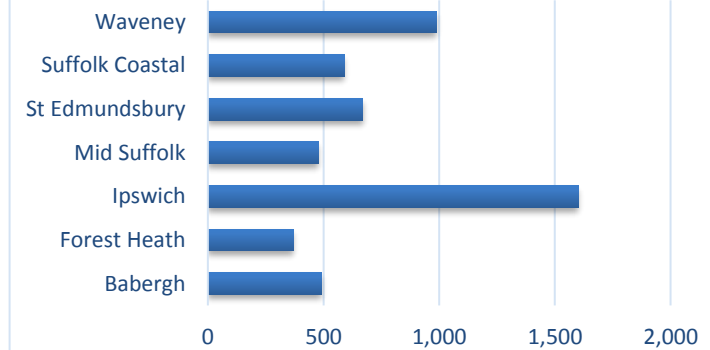
A Disability Allowance is given to an adult if they need help looking after themselves or have walking or mobility difficulties. The number of over 50's in Suffolk claiming a Disability Living Allowance has reduced 23% (17,120 to 13,170) from February 2014 to February 2017.

Persons claiming Carers allowance in Feb 2017 in Suffolk



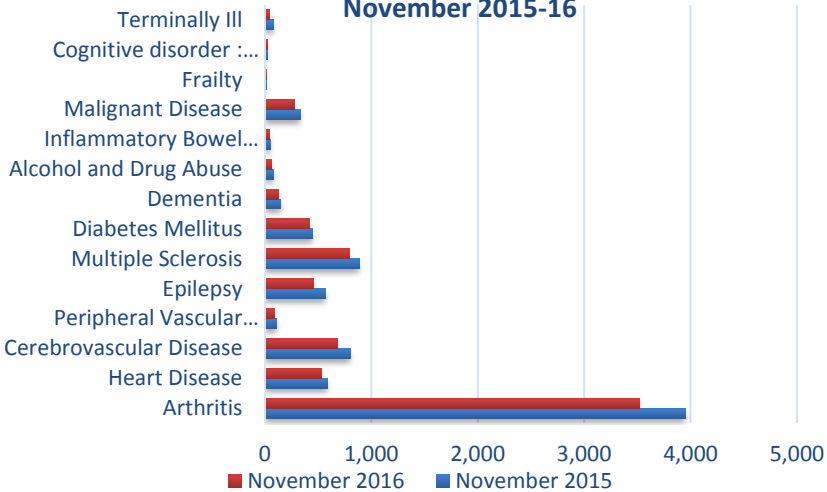
Carer's Allowance is for people who spend at least 35 hrs/week providing regular care to someone who has a disability. Waveney had the highest number of people aged 45-64 who are receiving a Carers Allowance (1,010), Babergh (410) had the lowest. Many OP, provide 50+hrs care a week, it is possible that a large number of carers are not aware of the benefits/ support available to them.

Number of people receiving income support in Feb 2017



To receive Income Support, one must be pregnant/a carer/a lone parent with a child<5 or unable to work because of sickness or disability. The number of people (all ages) receiving income support in Feb 2017 was highest in Ipswich (1600) and lowest in Forest Heath (370).

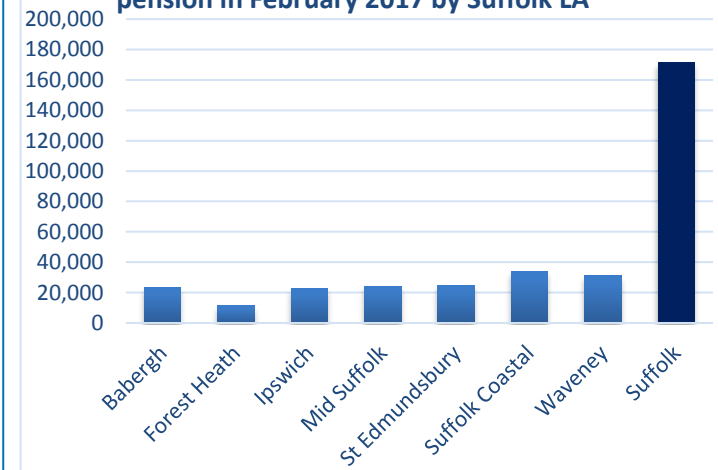
Disability Living Allowance by disabling condition from November 2015-16



← Arthritis is the highest disabling condition for which a Disability Living Allowance was claimed, however a reduction in cases was seen from November 2015 to November 2016 (3,950 to 3,520). Cerebrovascular Disease, Multiple Sclerosis, Diabetes and Malignant Disease were the next highest conditions for claiming a DLA.

State Pension is a regular payment from the government that you can get if you reached State Pension age. The number of over 60's receiving a state pension as of February 2017 in Suffolk's LAs were highest for Suffolk Coastal (34,130) and Waveney (31,170) and lowest for Forest Heath (11,240), which are reflective of both population age and size. →

Number of over 60's receiving a state pension in February 2017 by Suffolk LA

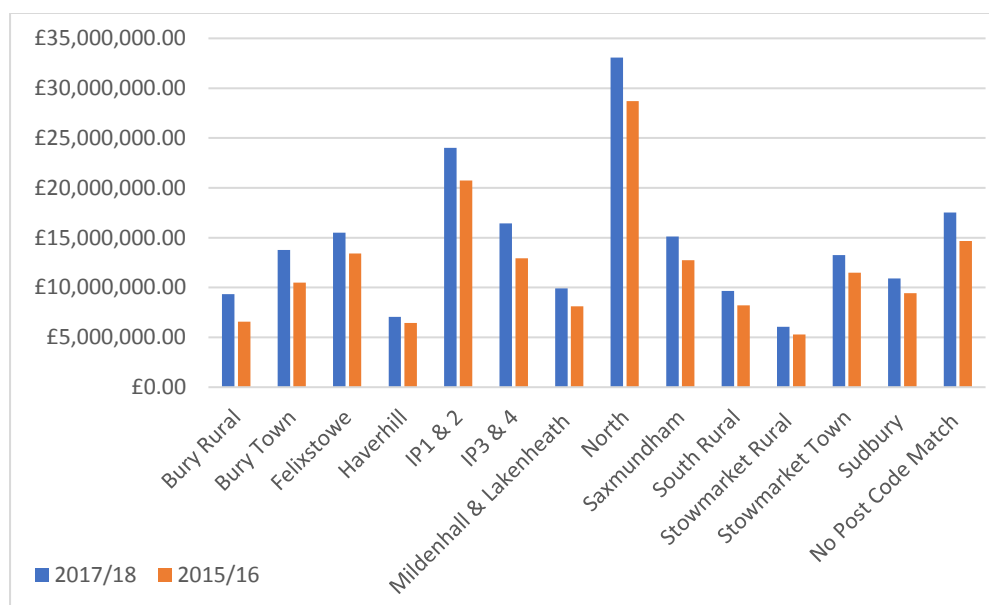


6.5 The cost of ageing

National analysis shows that not only is more than 40% of the NHS budget spent on the over 65 population but an 85-year-old male costs the NHS, seven times more than a man in their late 30's.⁷⁴ Suffolk spent £84m in 2013/14 on urgent care for the over 65 population. This is projected to grow by at least £12m pa until 2019/20 due to the change in age demographic alone.⁷⁵

Data is available for the spend for each Integrated Neighbourhood Team (INT). The projected spend for each INT in 2017/18 is higher than the total spend 2 years ago in 2015/16. North INT has the highest overall projected spend in 2017/18 at just over £33 million and Stowmarket Rural has the least projected spend at £6 million. It must be noted that North INT had the highest no. of service users (2,526), which is reflective of its population size. (Figure 72)

Figure 72: Connect areas locality spend-2015/16-2017/18



*This data has been sourced from the ACS business intelligence tool and is reflective of the reporting within the social care database by social care practitioners and should not be used as the actual social care spend figure as there are aspects of spend that will not be recorded on the system.

Findings from the Symphony project⁷⁶ in Somerset which looked at multi-morbidity, health and care utilisation and costs across the population suggest that higher costs were related to the number of comorbidities an individual had rather than age alone. It is also important to highlight, as noted elsewhere in this report, the significant economic contribution those aged over 65 make to individuals and to the wider society. This contribution could potentially be greater if we ensure older people stay healthy and independent and remain productive or in work. This therefore underscores the importance of prevention in promoting or supporting healthy ageing.

Summary: Socioeconomic and environmental conditions

- ❖ The proportion of household's fuel poor in Suffolk (9.1%) is considerably higher than the regional average (7.8%).
- ❖ Mid Suffolk, Babergh and Waveney local authorities have the highest proportion of household's classed as fuel poor.
- ❖ Excess Winter Mortality figures show that Forest Heath has the highest EWDI for those aged 65 and over, and Waveney the lowest.
- ❖ Analysis by CCG shows that WSJCCG has the highest EWDI for those aged 65 and over while GYJCCG has the lowest. Analysis by age shows that in all three CCGs, the EWDI is highest in those aged 85 and over.
- ❖ As the number of older people in Suffolk grows, the more vulnerable are at risk of suffering the ill impact of unsafe, unhealthy and unsuitable homes. The ['Suffolk Housing and Health Needs Assessment'](#) highlights the growing need to ensure that older people have access to appropriate and affordable housing options that meets the requirements of additional needs older people may have.
- ❖ Interventions to promote older people as well as the younger generation to remain in work for longer can have notable effect of healthy ageing.
- ❖ Maintaining a purpose in life helps retain physical function amongst older adults. Working later in life benefits individuals by keeping them socially connected and financially secure.
- ❖ State Pension age will increase for both men and women to 66 between 2018 and 2020 and even further to 68 between 2044 and 2046. However, only about 70% of people aged 50-64 are in work and less than half of people are still in work the year before they reach state pension age. Work places therefore need to adapt working styles and opportunities to suit the needs of an older workforce.
- ❖ Between 2015/16 and 2016/17 the number of those aged 50 and over and in employment was highest in Ipswich and lowest in Babergh and Forest Heath. The number of males aged over 50 and in employment increased in all districts but Suffolk Coastal, Babergh, Waveney and Ipswich saw a reduction in the number of females aged over 50 and in employment.
- ❖ Suffolk Coastal has the highest number of persons who are economically inactive due to being retired. Ipswich, followed by Waveney, has the highest proportion of individuals classed as economically inactive because they are "looking after a home or family" as well as due to being long-term sick or disabled.
- ❖ In Suffolk 12.4% of those aged 60 and over live in income deprived households compared to the England average of 16.4%.
- ❖ Many older people provide 50+hrs of care a week, but a large number are unaware of the benefits / support available to them.
- ❖ Suffolk spent £84m in 2013/14 on urgent care for the over 65 population. This is projected to grow by £12m pa. until 2019/20 due to the change in age demographic alone. Evidence suggest that higher costs are related to the number of comorbidities an individual has rather than age alone, underscoring the importance of prevention in promoting or supporting healthy ageing. It is also important to note that despite these costs society benefits from the skills and economic contributions of older people.

7. EXISTING SERVICES

In this section the wider determinants of health framework is used to map services in Suffolk relevant to healthy ageing. In view of this, the types of services that could be categorised as promoting healthy ageing are potentially numerous.

To facilitate the mapping, a healthy ageing ‘service mapping template’ was sent to a variety of contacts on the Suffolk InfoLink distribution list. Responses were received from 38 organisations who provide a healthy ageing service, activity or initiative. Given the breadth of healthy ageing, and the fact that not all the service providers contacted responded, the findings should be seen as providing a snapshot of what is available in Suffolk or as an **example** of services are available.

The findings are presented below, with services grouped using the wider determinants of health framework. Underneath each subgroup of services listed, one of two examples of services with clear demonstrable impacts have been highlighted and presented in more detail. It is recognised that there may be overlap between services as some healthy ageing initiatives provide interventions that affect multiple wider determinants of health e.g. some initiatives provided in a group/community setting will have a beneficial impact on social and community networks.

Services addressing individual lifestyle factors:

Service	Location	Lifestyle Factor	Description
Active Living	Bury St Edmunds	Physical Activity	The service targets patients from clinical referrals to increase fitness, through gym, water and leisure exercises. ~40 participants aged 60+ receive the intervention per month from July 2017.
Cancer Rehab Exercise Programme	Sudbury	Physical Activity	Exercise programme to aid recovery of people with cancer (patients, carers, family) and prevent reoccurrence. Mainly 50+ British participants.
Chair Yoga in Care Homes	Woodbridge	Physical Activity	Yoga for elderly residents in care to improve mobility, breathing, stress and community spirit.
Parkinson’s Support Group	Felixstowe	Physical Activity	To improve physical balance, strength and coordination in the over 60’s who have Parkinson’s disease. Have delivered to 108 participants at the time of writing.
Fit Villages	All Suffolk	Physical Activity	Aimed to bring physical activity to rural villages, for those aged 55 years and over.
Taoist Tai Chi Society	Ipswich, Woodbridge Felixstowe Lavenham	Physical Activity	Gentle but powerful exercise giving flexibility to joints and muscles, calming the mind, aiding balance. Suffolk

			branch has 300 members, 79% are 55 and over at October 2017.
Gainsborough Library	Gainsborough	Physical Activity	Exercise aimed mainly at older people and people with disabilities.
ActivIpswich	Ipswich	Physical Activity	ActivLives and IBC partnership focusing on 45+ who are not active.
Sporting Memories	Suffolk	Physical Activity	Dementia, depression, loneliness and inactivity through Sporting Memories. At least 5 Sporting Memories Groups are being established in Suffolk over the next 12 months in 2018.
Good Gym	Ipswich	Physical Activity	Although not directly engaging older people in activity a novel way of using activity (i.e. running) as a way of tackling isolation in older people. Good Gym Ipswich launched 4th September.
Breathe Easy	Bury St Edmunds	Smoking	Patients or members of family who have a lung disease can talk to others, build friendships, and receive help, advice and support from others in the group.
Chefs Delight	Thorndon, Eye, Stowmarket	Diet and Nutrition	Promotes healthy eating amongst older adults with physical disabilities, through cooking sessions and quizzes.
Holiday Homes Trust	Suffolk	Leisure	Holiday Homes for older people with learning disabilities help disadvantaged families to feel less isolated and will provide a recuperative break.

SPOTLIGHT: Fit Villages

Fit Villages is delivered by Suffolk Sport funded through Most Active County Partnership Programme, Sport England's Community Sport Activation Funding (CSAF) and Suffolk Sport until 2016/17. It has been implemented throughout Suffolk with the aim of bringing physical activity to rural villages, therefore addressing a gap that had been identified. The service targets those aged 55+. In 2017/18 it has targeted 390 participants. Evaluation has shown that those involved in the programme have shown significant changes in their weekly moderate and vigorous physical activity, as well as much wider benefits especially through improvements in social isolation and building community networks.

Services addressing social isolation and community networks:

Service	Location	Social Isolation/ Community Networks	Description
<i>Haverhill Life Link Project</i>	Haverhill	Social Isolation/ Community Networks	Haverhill LifeLink supports those living in and around the town by aiming to connect people to the many social activities, clubs and groups that are on offer in the community.
<i>Cancer Support Sudbury</i>	Sudbury	Social Isolation/ Community Networks	Peer support, signposting, social activities for cancer patients/family/carers in a more informal setting for adults. 40 persons, majority 50+ seen from July to October 2017. Case studies show they greatly benefit from peer support, information provided.
<i>Driving Miss Daisy</i>	Newmarket Ipswich	Independence/ Social Community	Companion driving service takes people out, who could not otherwise get out of their homes independently. 36 people have been seen from July to October 2017.
<i>Hadleigh Probus Club</i>	Hadleigh	Social Isolation/ Community Networks	Promotes fellowship amongst retired and semi-retired professional and business men. 30 people have participated from July to October 2017 with majority aged 70+.
<i>Timeout Halesworth Library</i>	Halesworth	Social Isolation/ Community Networks	Provides a friendly, relaxed interesting group where people over 50 can meet new people so they are not lonely. Around 25 attendees a week.
<i>Gainsborough Library</i>	Gainsborough	Social Isolation/ Community Networks	Provide a variety of activities for social participation amongst older people. Have seen approximately 50 people attended from July to October 2017.
<i>The Hope Trust</i>	Felixstowe	Social Isolation/ Community Networks	Aims to reducing the impact of loneliness for people aged 50+, had 578 attendees from July-Sept.
<i>Seagull Theatre Knitting Club</i>	Suffolk	Social Isolation/ Community Networks	A knitting club with 26 members who knit with the aim to combat loneliness and gain companionship.
<i>Sue Ryder The Stables</i>	Ipswich	Social Isolation/ Community Networks	To provide respite and social care to people with dementia in a care home setting, 35 people registered at the time of writing this report.
<i>Men's Shed</i>	Suffolk	Social	Helps provide men with a real purpose after retirement/widowhood/ill health and the skills that they are bringing together

			and new skills they are learning are keeping brains active and engaged. 26 members currently.
Holiday Homes Trust	Suffolk	Social Isolation	Holiday Homes for older people with learning disabilities help disadvantaged families to feel less isolated and will provide a recuperative break.
Parkinson's Support Group	Felixstowe	Social Isolation/Community Networks	Carers get together, informal outings, group meetings have helped 150 patients/families/carers with Parkinson's in the from July to October 2017.

SPOTLIGHT: Haverhill LifeLink Project

The Haverhill LifeLink Project (partly funded by Public Health Suffolk for 2 years as part of a number of social prescribing projects), is aimed at anyone over the age of 16 to connect to people living in and around the area. It is a bespoke service that offers members up to six hourly sessions with a LifeLink Coordinator, access to the Haverhill LifeLink drop-in sessions to produce a personal action plan. Participants are currently referred from one of the GP practices in the area but can also be self-referred. It further joins the dots across the many voluntary and community opportunities within the town, therefore ensuring sustainability and accessibility. The benefits received range from improved mental health and wellbeing, meeting new people and developing new friendship, feeling healthier and fitter, learning new skills, and as a result opportunity for volunteering and employment.

Services addressing education:

Service	Location	Education:	Description
Parkinson's Support Group	Felixstowe	Education:	To support, educate and help people with Parkinson's and their carers on health matters, through speakers from social and health sectors.
University of Third Age (U3A)	Lowestoft	Education:	416 members of retired or semi-retired people in October 2017. Education groups following agreed areas of interest and learning from each other.
University of Third Age (U3A)	East Suffolk	Education:	To advance the education of the public in East Suffolk, in particular the education of older people no longer in full time gainful employment. Has a membership of 2,200 people mostly aged 55+ in 2017.

SPOTLIGHT: University of Third Age (U3A)

U3A is a volunteer led organisation which offers educational and social activities for older people. The East Suffolk branch of this covers, Ipswich, Felixstowe, Woodbridge, Saxmundham, and surrounding towns and villages. It currently has a membership of over 2,200 people, mostly who are aged 55+. For an annual cost, members can join a speaker programme, more than 160 interest groups and short courses. In the 2017-18 ongoing session, there have already been 27 talks. Global evaluations of the U3A have shown that opportunities for lifelong learning and social relationships offered through these programmes will have impacts on wider determinants in life such as employment, reduced dependency, and wellbeing.

Services addressing care/carers:

Service	Location	Care/Carers:	Description
<i>Dementia Together</i>	Suffolk (excludes Waveney)	Care	Suffolk CCGs, SCC, Purple Tuesday have come together, to provide a service or Carers or those cared for that are affected by Dementia or memory worries, with the purpose to navigate these people through services. 270 people have been registered in total.
<i>Tender Loving Care Suffolk</i>	Bildeston surrounding villages	Care	Domiciliary Care and Support Services for elderly people, to avoid referral to a Care Home.
<i>Walton Parish Nurses</i>	Walton, Felixstowe	Care	Through drop ins, home visits, exercise classes has helped 50 people in from July to October 2017 to provide whole person health care.
<i>St Nicholas Hospice-Open House</i>	West Suffolk	Care Education Nutrition	Open House aimed at people facing long-term and life-threatening illnesses, loved ones, carers, or those coping with bereavement. mini-educational segments also around breathlessness, managing fatigue and nutrition. 1147 participants from July to October 2017.
<i>Suffolk Family Carers</i>	Suffolk Wide	Carers	A range of information, advice, guidance, workshops, training, advocacy and other support for carers of all ages, including older carers.

SPOTLIGHT: Dementia Together

From April 2017, Suffolk County Council, IESCCG and WSCCG jointly commissioned 'Dementia Together', which is provided by Sue Ryder along with Norfolk and Suffolk Dementia Alliance, University of Suffolk, and Purple Tuesday. The primary aim of the service is to provide more joined up support for people with Dementia and memory problems and to provide a single point of contact, allowing more timely, efficient provision. Sue Ryder is specifically working with Dementia Action Alliances within East and West Suffolk for the delivery of this project. As of January 2018, the project has helped more than 600 people and recently also won the CCG and Local Authority Integrated Commissioning for Carers Award at the Health Service Journal Awards in November 2017.

Services addressing housing and health:

Service	Location	Description
<i>Warm Homes/Healthy People</i>	Suffolk	For those with health conditions who are struggling to adequately heat their homes, with the aim to reduce excess winter mortality and fuel poverty. ⁶⁵
<i>Surviving Winter Campaign</i>	Suffolk	Suffolk Community Foundation's Surviving Winter Campaign allows residents who are eligible for a winter payment to donate their payment to those most in need. Over 5 years, £310,000 helping 850 people.
<i>Suffolk Home Improvement Agency</i>	Suffolk	Home improvement agency that assists people living in Suffolk who are elderly or vulnerable, have disability needs, on a low income, who need need help to repair, improve or adapt their home so that they can continue to live safely and independently in their home.
<i>Night Shelter</i>	Ipswich and Bury St Edmunds	Provides temporary shelter accommodation during the coldest 3 months of the year to those who are homeless or disadvantaged, which can leader to future secured accommodation.
<i>Drop in Support</i>	BSE/Brandon	Drop in providing support, health contact, advice and guidance to those most vulnerable in communities. Also offers food and drink and signposting.

SPOTLIGHT: Warm Homes/Healthy People

'Warm Homes Healthy People' is an initiative that offers support to those with health conditions who are struggling to heat their homes with the aim to reduce excess winter deaths and fuel poverty. In 2016/17 the service received nearly 5000 calls, conducted 529 free home energy surveys, 570 heating installations or repairs and awarded £19,000 in fuel payments. In the 2015/16 winter the service worked with Ipswich Hospital Trust and reduced delayed transfers of care due to heating in homes, saving an estimated 21 bed days. The same initiative is planned for West Suffolk Hospital this winter.

National mandatory services:

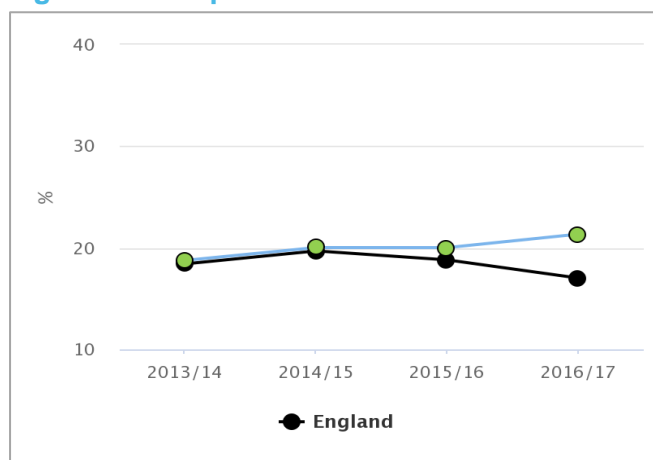
NHS Health Checks

The NHS Health Check programme is a mandatory public health service for the local authority, which includes 5-yearly vascular risk assessment and management programme to help prevent cardiovascular diseases. The programme targets individuals who are aged between 40 to 74 years and have had no previous diagnosis of CVD.

Prior to the programme, it was estimated that health checks could prevent 1,600 heart attacks and strokes, at least 650 premature deaths, and over 4,000 new cases of diabetes each year. At least 20,000 cases of diabetes or kidney disease could be detected earlier, allowing better management of these conditions and improved quality of life. The estimated cost per quality-adjusted life year is approximately £3,000. (Quality adjusted life year (QALY) is defined as a year of life adjusted for its quality, so that 1 QALY is equivalent to a year of life lived in perfect health. QALYs are calculated by estimating the years of life remaining for an individual following some treatment or intervention and weighting each year with a quality-of-life score on a 0 to 1 scale.)

In Suffolk, the target for uptake NHS Health Checks was set at 66% for 2016//2017. During this period, 47,536 NHS Health Checks were offered, with 28,242 individuals receiving the NHS Health Checks resulting in an uptake of 59.4%. Although Suffolk achieved slightly under the set uptake target for 2016/17, the highest number of health checks were delivered during this period since the programme began. Figure 73 shows the percentage of eligible people who were invited for a health check over the past four financial years, the graph indicating an increase from 2014/15 to 2016/17. Suffolk was the 2nd best performer in the East of England and 29th nationally out of 152 local authorities for people who have had a NHS Health Check between Q1 2013/14 and Q3 2016/17.

Figure 73: People invited for an NHS Health Check per year-Suffolk



Source: Public Health England, Fingertips

National Diabetes Prevention Programme

The National Diabetes Prevention Programme (NDPP) is another national initiative which was announced in the NHS 'Five Year Forward View'⁷⁷ and Public Health England's 'Evidence into Action'. The programme provides "tailored, personalised help to reduce the risk of individuals developing Type 2 diabetes, including education on healthy eating and lifestyle, help to lose weight and bespoke physical exercise programmes, all of which together have been proven to reduce the risk of developing the disease"⁷⁸. Between June 2016 and March 2017, the programme received 43,603 (national) referrals with an attendance rate of 49% to the first session of the programme.

The programme is being rolled out in three waves, across STP geographies nationally and the first two waves have been completed. Suffolk is part of the wave three roll-out; it is anticipated that the programme will be in place across the Suffolk and North-East Essex STP in July 2018.

Gap analysis:

The service mapping exercise above, whilst not representative of all healthy ageing services available in Suffolk, has exposed some gaps in service provision. Listed below are issues various service managers have identified as challenges and barriers they face in service delivery:

- In general, all services face problems contacting those in need of that service. Smaller services usually rely on people coming to or contacting them. However, people tend not to proactively do so, meaning at times, very low numbers access the service.
- Physical activity services face problems in reaching those that are truly physically inactive as those who are more active are likely to attend. Furthermore, achieving behaviour change is very challenging in those who are less active.
- Involving younger people/younger adults is difficult, as there is a lack of understanding of healthy ageing and the need to accrue the benefits much earlier.
- Males are less likely to attend initiatives to promote social participation e.g. activities in libraries.

- Attracting volunteers is a big problem for all services.
- There is a need to find, reach and engage with the hard to reach groups of older people, including those who resist help to reach them.
- For homeless people, there is a lack of mental health care / support and lack of suitable supported accommodation for those with extra needs.
- There is a need for more services for healthy eating to emphasise the impact it can have on individuals. Carers also need education on healthy eating to help reinforce the message and encourage improved diet and wellbeing.
- Finance and funding for charities is a continuing problem.
- Difficulties in marketing services to those in need; better promotion of services is needed.
- There is a gap regarding suitable housing for older people and a growing need to ensure that suitable housing options are available to people as they age. More detailed information regarding housing is available in the recently published housing [needs assessment](#)⁶⁵ published on the [Healthy Suffolk Website](#).

Whilst there are ample services available for lifestyle factors most notably for physical activity, services for healthy eating are limited. The number of initiatives to promote social and community networks is growing and presents a promising picture, however the attendance at these is low. Low uptake could be attributable to several reasons e.g. lack of accessibility, mental health issues, and transport issues. Few services are available to raise public awareness of ageing and older of people and the wider benefits to society. Continued employment for older people for example is crucial and beneficial to our economy, given our ageing population. Our service mapping has identified a notable gap in services or initiatives to promote or support older people to stay in work or volunteer for longer within Suffolk. There are however examples nationally which are detailed in Section 9: Evidence of Effectiveness.

8. SERVICE USER EXPERIENCE

A needs assessment steering group representing key stakeholders (listed on page 103) was set up to oversee this needs assessment. Whilst there was no direct service user engagement undertaken as part of the needs assessment, stakeholders were asked to share feedback from relevant user engagement activities they had undertaken. The findings are summarised in this section.

Age UK Suffolk undertook some service user engagement in December 2016 on behalf of Suffolk County Council to explore older people's views on existing services within Suffolk. 350 people, (105 male and 245 females) aged 55-98 years were interviewed as part of this engagement by either one to one interviews at their own home (65 participants) or interviewer completed questionnaires during group events (285 participants). The residence of participants in each Suffolk district or borough were:

Number of people aged 55-98 interviewed in Suffolk			
Babergh	33	St Edmundsbury	77
Forest Heath	39	Suffolk Coastal	49
Ipswich	47	Waveney	70
Mid Suffolk	35		
Total: 350			

Key issues that older people raised about ageing were:

- The understanding of 'assistive technology' is poor amongst older people, with more than half of both men and women over 65 years not having heard of or understood the term 'Assistive Technology'.
- Men and women both feel that they would in general be able to communicate with medical staff using a computer or video link, but there is also a feeling that 'face to face' consultations would be preferred.
- Adding bars and rails around the home, adaptations to the bathroom with wet rooms, home adaptations including: widening doors, raising chairs, and ramps to support wheelchairs are very helpful in maintaining independence.
- Women are more likely to plan ahead than men in making practical provision for their care needs in case they find that they can no longer cope on their own.
- There is a lack of knowledge amongst older people about changes and rules and regulations around social care.

When asked what practical things could be done to make life easier and what challenges they faced, service users expressed five main issues. Below is a list of the issues accompanied with service user quotes.

1. Transport

"I couldn't afford the maintenance costs of cars so had to give it up"

"more frequent buses, or buses stopping at closer intervals"

“a bus service or some flexible way of getting around”

2. Getting Out and Getting Around

“I would like to go out but I have no one to take me”

“more information on where wheelchair accessible toilets are”

“more neighbours to pop in and help”

3. Personal Care and Attention

“someone to do the small things and practical everyday things-you can't care on your own”

“Someone to show me how to use the internet on my tablet

4. Home Adaptation

“The best thing would be a downstairs toilet”

“It will the best to have a handrail, a wet room and a stairlift”

5. External Issues

“A dropped kerb outside for wheelchairs”

“Pavement repairs and fixing uneven surfaces”

This stakeholder engagement identified that the main concerns of older people who responded were around health and care issues, lack of social contact and finance. However older people also showed a sense of positivity for the future and showed acceptance of their situation.

- *“we have everything we need”*
- *“I don't think so, we have everything we could expect to have”*
- *“I'm quite happy doing what I'm doing”*

It is anticipated that further stakeholder and service user engagement will be undertaken in the future to inform the development of a healthy ageing strategy for Suffolk and ongoing work to make Suffolk an age-friendly county.

9. EVIDENCE OF EFFECTIVENESS

9.1 Evidence review

This section summarises the findings from an evidence review undertaken as part of the needs assessment. It aims to identify and review available literature on the effectiveness of initiatives to support healthy ageing and examples of best practice.

Methodology

The evidence review comprised of literature searches of the following resources:

- Medline, Embase, CINAHL, PsycINFO, TRIP database
- Research organisations - NICE, Cochrane, Social Science Research Unit
- Google Search for Grey Literature and Internet resources
- An Evidence Search request was also carried out by NELFT Library Services.

The literature identified was grouped into 6 pre-determined categories prior to further assessment. These categories were:

1. General Healthy Ageing Programmes
2. Lifestyle
3. Community Networks and Social Isolation/Loneliness
4. Environment, Workforce and Technology
5. Dementia and End of Life
6. NICE Guidelines regarding older people

Each category has detailed findings found in tables 1-6 in the Appendix. A summary of each has been provided in this section.

We included:

- Literature published from 2005 onwards
- Literature on programmes or strategies from EU countries, North America or Australia

We excluded literature on healthy ageing programmes or initiatives targeted only at children only with no adults as the outcome of interest.

Summary of findings:

The main findings from each category have been summarised below. Each category has been separated into "background, recommendations and evidence" where appropriate. For detailed findings please refer to the tables 1-6 in the Appendix.

Category 1: General healthy ageing programmes

Background:

- Healthy Ageing should be approached by taking a life course approach. There is an association between adverse childhood events and negative health and wellbeing outcomes in later life. Evidence favours intervention and prevention as early in the life course as possible.⁴³
- Evidence has shown that focusing on the impact of: physical activity, socioeconomic inequalities, fuel poverty, unemployment, built environment, mental health, social isolation, caring responsibilities, and ethnic group inequalities will provide the most benefits in the long term.
- A study developed a healthy aging score (HAS) to assess age and sex differences found that levels of HAS were lower in women compared with men, in all age categories.⁷⁹ The HAS declined more steeply for women than men as they age.

Recommendations:

- WHO has identified 5 priority interventions to support healthy ageing. Falls, Physical Activity, Flu Vaccination, Informal Care Giving and Older Workforce.
- Using electronic patient records is recommended as it is timelier and promotes integration of health and social care services for older people.³⁶

Examples/Evidence

- Carer Passports in hospitals are schemes being developed to identify carers and provide support through the NHS. During the pilot in Manchester, 59% of staff felt it had improved communication between staff, patients and relatives. The need for carers to have an annual health check was also raised, which could be monitored through the app.
- Surrey CCGs have Carer Prescriptions on the app through which carers are referred onto other support services.
- Carers UK have developed a care coordination app called 'Jointly', which creates care circles and can assign tasks and helps joint communication. Qualitative interviews have reported outcomes of "being able to stay on top of things and sharing information with everyone involved in patients care".
- There has been some notable UK projects such as POPPS and New Dynamics of Ageing Programme which were aimed at promoting health, well-being and independence. In the POPPS programme (2005), 100K people received the service, and it was estimated for every £1 spent, an average of £0.73 would have been saved per month on cost of emergency hospital bed-days.
- Some UK based innovative practices around healthy ageing (from the European Commission's Innovation Partnership for healthy and active ageing) are:
 - Refer to Pharmacy
Electronic Tool for bedside referral (evaluation ongoing, 1,777 electronic referrals to community pharmacy in 7 months)
 - Electronic Frailty Index (eFI)
uses routine GP data to develop integrated care for those with frailty. Studies testing the effectiveness have given mixed results. More evaluations are needed.
 - Altogether Better
National NHS network organisation aims to deliver models on the basis of coproduction
 - Managing active and healthy ageing with use of caring service robots (MARIO)
Challenges of loneliness, isolation and dementia in older persons through interventions delivered by caring service robots.

Category 2: Lifestyle

Background:

- The influences on physical capability in terms of socioeconomic position, lifestyle, underlying physiology and genetics all can affect later health.
- Studies on weight loss showed that diet in combination with exercise and nutrition counselling, and counselling on its own all can lead to reduced weight in older people.
- CMO guidelines state that “Older adults who participate in any amount of physical activity gain some health benefits, including maintenance of good physical/cognitive function. Some physical activity is better than none, and more physical activity provides greater health benefits.”

Recommendations:

- Oral health- oral health and functional tooth retention later in life provides benefits both in terms of oral and general quality of life and in terms of preventing physical decline and dependency. Barriers to oral health care must be addressed.
- Food security is an important factor in a healthy old age; food security consists of an older adult being confident to be able cook themselves or have the arrangements to be provided with food themselves.

Examples/Evidence

- Fit as a Fiddle (Age UK) - Two nationwide programmes to support people aged over 50 with physical activity (PA), healthy eating and mental well-being through educational and training programmes. Supported 375,392 older people. Evaluation has shown, 'impact on levels of activity, eating, and wellbeing measured on numerical scales. However, few recorded instances of negative outcomes, such as injury or illness.
- Ageing Well (Scotland) - Has targeted 50,000 people. The evaluation suggests half the people who have taken part have taken steps to improve wellbeing, PA and healthy eating. Qualitative data has shown improvements in information exchange and network/capacity building. However, some records that the programme should have been promoted more for a wider roll out.
- Care About Physical Activity initiative, Scotland (CAPA) - This resource offers support for everyone in a care home to get involved and become physically active. Evaluation has shown care home managers as positive. 50% of homes have used the resource in resident's care planning. SCC is currently working with project lead to develop a self-assessment toolkit for Suffolk.
- Project ACE, South West - Evaluation of the ACE programme shows that it had a considerable impact on the health and social outcomes of the participants, with 55% on intervention group showing increase in vitality, compared to 22% of control group.
- Suffolk Fit Villages Project designed to fill a gap in provision of PA in rural areas. Evaluation of the project showed that the number of minutes spent in weekly vigorous PA increased from 15.9 minutes at baseline, to 52 mins at 3 months follow up, $p < 0.001$. Weekly walking baseline (71.5mins) also went up in the 3 months follow up (90.3 mins) $p < 0.001$. Increases in social interaction and isolation were all seen with statistically significant results $p < 0.001$
- Alcohol- Research has shown that vulnerability to harmful drinking practices can be brought by sudden change of routine in those ageing. The use of imposed routines to limit alcohol use and decreasing alcohol intake as people age can be a solution.

Category 3: Community networks and social isolation/loneliness

There is lack of high quality evidence to demonstrate the impact of different interventions on loneliness and social isolation. The limited evidence available highlighted the following points:

Recommendations:

- There is good evidence that older people who make voluntary contributions report:
 - An increase in the quantity and quality of their social connection
 - An enhanced sense of purpose and self-esteem
 - Improved life satisfaction, happiness and wellbeing
- Commissioners, clinicians and providers should explore how they can:
 - Understand and better exploit the network around the older person
 - Map who provides support from the community before crises happen, so that these support networks are not lost at key transition points such as bereavement, a significant spell in hospital or when an older person stops driving
- Age UK suggests the most effective community-based approaches are neighbourhood approaches, asset-based community development, volunteering, age friendly cities

Examples/Evidence

- 'Make Do and Friends' project - The role of Arts in Healthy Ageing is a growing phenomenon. Suffolk Artlink, Dance East, and the Rural Coffee Caravan are three organisations are part of an outreach programme for 'participatory and inspirational arts' which aims to connect older people, strengthen communities and improve loneliness and rural isolation. The programme will begin in spring 2018 to 2020, therefore evidence of impact is unavailable.
- Brighter Futures - A pilot peer mentoring service for isolated older people and marginalised communities run by the Mental Health Foundation in Scotland. Evaluation identified improvements in perceived social isolation for 74% participants after 9 months with numerous supporting positive qualitative data results.
- 50 plus net - A virtual meeting place for those over 50 in Netherlands aiming to increase social participation, with more than 33, 000 active members. Qualitative evaluation has shown participants feel they have gained new contacts and have received support and advice from others.
- Age UK-Index of Wellbeing in Later Life⁸⁰ used statistical analysis on a number of factors to explain the percentage effect of over 40 indicators on an older person's wellbeing. Results showed that out of the 40 indicators the largest negative effect on wellbeing was having a diagnosed health condition or a long-standing illness or a disability at around -4%, other negative impact indicators were a financial debt and higher intensity caring responsibilities. The largest positive impact on wellbeing on the other hand was engaging in creative and cultural participation and physical activity producing a positive impact of over 5%.
- Suffolk County Council has recently started a '5 ways to wellbeing' promotional campaign which targets 5 components to improve one's wellbeing: physical activity, connectedness, taking notice of change, continued learning and giving back to the community. Although recently started, this can be seen as an initiative to benefit the wider determinants of health, with evaluation results to follow.

Category 4: Environment/ workplace and technology

Category 4a: Technology

Recommendations:

- The evidence base for using technology to enhance care is large, complex and continuing to grow rapidly. Evidence has shown rapid increases in those aged 65 and over using the internet from only 9% using the internet in 2006 to 42% in 2014.
- For older people, the most immediately beneficial use of technology may be maintaining social links and preventing loneliness but can be used for condition specific problems such as: dementia, falls, incontinence, delirium.
- Suffolk is among the bottom nine administrative authorities in England for internet speed and coverage. Older residents in areas with a poor internet infrastructure are at risk of becoming progressively more disadvantaged. It is important that care homes consider the needs of their residents for WIFI access.
- Many websites are poorly designed and are not fully accessible to older users, and it is important that local and national services which increasingly moving to 'online only' models ensure that their website are viewable and navigable to all.
- Various studies have shown that apps that use 'gamification' (using game design elements to improve user engagement) such as motivating participation and engagement) may prove increasingly important in helping to improve the overall wellbeing of older people but also be used in cognitive and physical therapy. But many apps are inaccurate and the efficacy of the majority of them is unknown.

Examples/Evidence

- Southend CCG: 2 devices were piloted in the Transformation through Technology project to be used for those with dementia and prone to wandering.
 1. *Just Checking*- has wireless Infrared sensors and 24hr web access to monitor activity
 2. *Mind Me Locate*- GPS tracker, Useful for those prone to wandering.
- CARESSES Project: (University of Bedfordshire) An ongoing project with the aim to design and evaluate culturally aware and competent elder care robots that adapt their interactions according to the culture of the person they are assisting.
- Coordinate My Care' Scheme (London) – Creates a shared health record between patients, carers and statutory organisations, providing people with life-limiting illnesses an opportunity to create a personalised care and end of life plan, which can be shared electronically with all legitimate providers.
- Technology Enabled Care Services (TECS) programme-The Department of Health encourages health care commissioners to consider investing in a variety of remote services, including wearable monitors, urine and blood analysers, blood pressure monitors, text messaging, movement sensors and alarms.
- Alzheimer's Society recently launched of a series of [information sheets](#) on dementia-friendly technology (for CCGs, Care Homes, Adult Social Care, GPs, Housing Providers) which can help people with dementia, and examples of technology that can help. Some examples of devices include: bed sensors, movement sensors, fall sensors, medication reminders, environmental sensors and enuresis sensors.

Category 4b: Environment / Workforce / Housing

Background:

- Leaving the labour market in later life and impacts on health⁸¹ A Dec 2017 article undertook multilevel analysis of data which showed that older people who are not in employment are at risk of poor physical and mental health. Interventions targeting social and mental engagement are valuable in providing opportunities for older people.

Recommendations:

- Employers need to:
 - Encourage flexible/agile/dynamic working for carers, review employee benefits to ensure that they are flexible enough, transfer knowledge between generations/encourage mentoring and enhance the profile of volunteering.
- House of Commons, Communities and Local Government Committee recommends:⁸²
 - Measures need to be in place to remove barriers to older people moving home.
 - Within the National Planning Policy Framework, the new standard approach to assessing need should explicitly address the housing needs of older people.
 - The range of housing for older people needs to be considered, in particular the potential for extra care housing to play a greater role in providing social care alongside home care and residential care.

Examples/Evidence

- Newcastle City Futures is undergoing a large scale urban development project to meet the complexities of an ageing population. It is novel in its approach as it is involving everyone in the city, engaging with partners from 22 disciplines.
- Hertfordshire Council-Has flexible retirement scheme, 'age neutrality' embedded into management training programme. Impact- 65+ are the most engaged staff group.
- Fuller Working Lives (DWP)- Many multinational organisations have adopted initiatives for older people:
 - *Aviva*-Mid-career reviews for over 50's
 - *Johnson and Johnson*-Flu vaccinations, cholesterol testing, H+W advice
 - *Jaguar Land Rover*- (Making staff feel valued) Piloting a retirement transitions initiative: Evaluation as shown 36% have reconsidered when they will retire.
- Chelsea and Westminster NHS Trust- Staff have access to a range of online support and information, up to 5 days paid emergency time off to care for dependents, and a flexible working policy: a recent survey showed 68% of staff felt the Trust helped them to achieve a good work life balance.
- Purpose in Life- In a 2017 longitudinal cohort study, a purpose in life was prospectively associated with a decreased risk of developing weak grip strength and slow walking speed, suggesting a sense of purpose in life may play an important role in maintaining physical function among older adults
- Dantas et al (2017)- The study found that for older people: female gender, poor visual perception, 4+ medications and 3+ comorbidities all were statistically significant reasons for not participating in the workforce. Later life is influenced by sociodemographic characteristics, strategies to help older people contribute to workforce or communities will be beneficial to healthy ageing.

Examples/Evidence

- Screening Buckinghamshire Residents in Care Homes for Dementia, Chiltern and Aylesbury CCG- A care home project was established using the DiADeM Tool – (Diagnosing Advanced Dementia) designed to be used only with those patients living with dementia within a care home setting.
- Young Onset Dementia (YOD)-patients are not matched to join more sedentary services designed for older age groups. There are few services, but some best practice includes Nottinghamshire, Leicestershire, Manchester and Cambridgeshire and Peterborough. Going forward we must think of project-based commissioning, and evidence of family borne costs related to age appropriate interventions.
- Royal Town Planning Institute (RTPI) - There is a RTPI virtual learning site for planners which now includes a module on Dementia. Some best practice includes- Worcestershire CCG who are focusing on creating ‘age and dementia friendly environments’.
- Belfast has been successful in its application to be a WHO Age Friendly City, it has developed an assessment tool to assess the accessibility of the built environment for older people and has had extensive stakeholder engagement with older people to involve them at all decisions points.
- Bradford- ‘The Face it Together’ project is led by people with dementia, involved with Dementia Friendly work and is seen as a leading example. Participants have provided feedback on dementia friendly signage and accessibility and advised on a hospital refurbishment and a new Westfield store to make it more dementia friendly.
- Dementia Awareness in Minority Ethnic Populations (Cambridgeshire and Peterborough CCG)- A Project to improve dementia awareness amongst South Asians, which included health checks for 200 people, hiring a specialist minority dementia support worker, organising a Dementia and Cultural Awareness Conference Workshop, and publishing a “Culture and Dementia Guidance”.
- End of Life-There have been several End of Life Initiatives that have been held over the last year: including the roll out of shared digital palliative and end of life care records, such as Electronic Palliative Care Coordination Systems (EPaCCS) to the majority of areas by 2018 and all areas by 2020. A ‘Faith at the End of Life’ report, by the CQC has been published which inspects whether people’s spiritual needs at the end of life are met and a ‘Best practice in care coordination for palliative and end of life care services: information for commissioners’ has also been published in 2017.
- The Serious Illness Conversations - A pilot being tested by sites in Airedale and Southend to support better personalised care in end of life. It has successfully led to extensive system change across the three pilot sites including: the development of a screening tool to identify ill patients; a questionnaire to enable conversations; and an agreed clinical workflow. All pilot sites are now considering ways to implement further going forward.

Full detailed tables of the available evidence and a list of NICE guidelines relating to older people are available in the Appendix.

10. CONCLUSIONS AND RECOMMENDATIONS

10. Conclusions and recommendations:

There is an underlying narrative in literature and policy that has portrayed older people as a social or financial burden for many years, affecting how we perceive ageing.⁸³ Presenting a novel approach to healthy ageing in Suffolk will require a change in the narrative and an emphasis on the opportunities and benefits an ageing population brings to us. Tackling ageism and embedding this intolerance in all practices, policies, and institutions will be crucial. The case studies presented in the report illustrate the fact that ageing can be a positive experience for Suffolk residents. Engaging communities to raise awareness and share best practice can also be of value to local communities.

Key themes arising from the findings from this needs assessment have informed the recommendations presented below.

Recommendation and rationale	Action by	How
<p>1. A continued focus on prevention across the life-course and reducing health inequalities.</p> <ul style="list-style-type: none"> • Healthy life expectancy has fallen, and people spend a significant number of years living with disability or in ill health. • Prevention, particularly in mid-life, will ensure that individuals live well and age well. • Lifestyle factors e.g. smoking, physical inactivity and poor dietary choices, and under-nutrition play a major role in driving ill health and health inequalities. • Deprivation has a significant impact on an individual's future and the disadvantage accrues over a life time. 	<p>The health and care system in Suffolk. This includes:</p> <ul style="list-style-type: none"> • All CCGs • Suffolk County Council (including Public Health, Adult and Community Services, Children and Young People's Services, Planning) • District and Borough councils • Ipswich & East Suffolk Alliance • West Suffolk Alliance • VCSE partners 	<ul style="list-style-type: none"> • Commitment to ongoing work to implement the Suffolk prevention strategy – "The Time is Now", which the whole system signed up to. • Ensuring that prevention priorities are embedded in key organisational and system-wide policies and strategies. • Increasing the number of staff across all organisations trained in "Making Every Contact Count" (MECC) and giving brief, evidence-based lifestyle advice. • Development of workplace health strategies across all organisations to promote staff health and wellbeing. • Targeted support for individuals to reduce inequalities in health outcomes.

<p>2. Action to improve the early identification and management of frailty.</p> <ul style="list-style-type: none"> • Suffolk’s population is ageing and the number of people living with frailty in Suffolk is expected to double in the next 20 years. • Frailty is significantly associated with multimorbidity in those with four or more long term conditions. • In 2037 there will be about 10 times the number of patients with 2 or more comorbidities than in 2017. • Multimorbidity is a key driver for cost, which suggests that our health and care system will be unsustainable if current trends continue. 	<ul style="list-style-type: none"> • Ipswich & East Suffolk Alliance • West Suffolk Alliance • General Practices 	<ul style="list-style-type: none"> • Further development of frailty identification and management pathways across the Suffolk system to include: <ul style="list-style-type: none"> ○ The adoption of tools for the routine identification of frailty e.g. the use of the <i>electronic Frailty Index</i> (eFI) in general practice ○ Implementation of best practice guidelines on the management of frailty e.g. NICE Guidelines on “Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset [NG16]”, British Geriatric Society (BGS) Guidelines ○ Consideration of emerging evidence on the identification of and management of frailty in the development of frailty pathways e.g. the need to include middle aged individuals with frailty, identifying individuals with long-term conditions associated with frailty
<p>3. More targeted work to tackle social isolation and loneliness.</p> <ul style="list-style-type: none"> • Social isolation and lack of community bonding remain a challenge and a risk to the physical and mental health of older people in Suffolk. • This is worse in some geographical areas in Suffolk • About 17,000 older people in Suffolk feel lonely. This is expected to rise to 25,000 in the next 20 years • An estimated 19,000 older people in Suffolk feel socially isolated 	<ul style="list-style-type: none"> • Suffolk County Council <ul style="list-style-type: none"> ○ Public Health ○ Adult and Community Services • District and Borough Councils • Ipswich & East Suffolk Alliance • West Suffolk Alliance • Community Action Suffolk and VCSE partners 	<ul style="list-style-type: none"> • Commitment to the Suffolk Health and Wellbeing Board Strategy priority on reducing loneliness and social isolation among older people. • Prioritising social isolation and loneliness as part of ongoing work to establish Suffolk as an Age Friendly County, particularly in areas considered most at risk e.g. <ul style="list-style-type: none"> ○ Over 65’s living in urban areas e.g. Ipswich and Mid Suffolk. ○ ‘Hotspots’ for social isolation in older people e.g. rural areas to the east and south of the county, around Lowestoft, Woodbridge, Stowmarket, Felixstowe, Sudbury and Leiston. • Continued engagement and involvement of older people in ongoing work to support healthy ageing.

	<ul style="list-style-type: none"> The total population aged over 75 predicted to live alone by 2035 is expected to rise by 70%. 		
4.	<p>Action to support carers, especially older carers.</p> <ul style="list-style-type: none"> There number of older carers (aged over 65) in Suffolk, including those providing long hours of care is increasing. The number of informal (family or unpaid) carers who feel socially isolated has also increased and is significantly higher than the national average. Carers play an important role in keeping the people they care for living at home. 	<ul style="list-style-type: none"> Suffolk County Council <ul style="list-style-type: none"> Public Health Adult and Community Services District and Borough Councils Ipswich & East Suffolk Alliance West Suffolk Alliance Suffolk Family Carers and other VCSE partners 	<ul style="list-style-type: none"> Ensuring that the needs of carers are considered in ongoing work to deliver the Suffolk Alliance strategies. Targeted support for carers to reduce social isolation. Review and refresh the Suffolk's Carers Needs Assessment and Strategy to ensure the needs of older carers are identified and addressed.
5.	<p>Action to improve the quality of care for care home residents.</p> <ul style="list-style-type: none"> The population living in care homes will rise significantly in the next 20 years. Care home residents are often the most vulnerable and dependent in the community, yet they experience inequalities in accessing NHS services to meet their needs. Some care homes in Suffolk are rated as inadequate or requiring improvement by the CQC. 	<ul style="list-style-type: none"> All CCGs Adult and Community Services Ipswich & East Suffolk Alliance West Suffolk Alliance Care home providers 	<ul style="list-style-type: none"> Engaging with and supporting care home providers across Suffolk. Addressing inequalities that care home residents experience in accessing health services to meet their needs. Implementing local approaches to enhancing health in care homes by: <ul style="list-style-type: none"> Implementing best practice guidelines and recommendations e.g. British Geriatric Society (BGS) guidelines, various NICE guidelines and quality standards e.g. on oral care, managing medicine, preventing falls, transitions between hospital settings and community or care home settings, mental wellbeing for people in care homes, etc. Considering learning from areas that have made progress towards addressing these issues.

6.	<p>Action to prevent age discrimination and to encourage businesses and employers to support older people and address the challenges older people in work face.</p> <ul style="list-style-type: none"> • As people age, employment rates fall and those in work feel less secure. • As the population in Suffolk ages, the working-age population will shrink. • It is therefore important that older people in Suffolk stay healthy, independent and remain productive or in work. This will support economic growth and sustainability across the Suffolk system. 	<ul style="list-style-type: none"> • Suffolk County Council • District and borough councils • All public and private sector organisations in Suffolk 	<ul style="list-style-type: none"> • Supporting older workers to remain in work, return to work or volunteer by: <ul style="list-style-type: none"> ○ allowing more flexibility ○ helping workers to adapt to employers' needs, re-skilling staff, promote working in different roles or different hours. ○ supporting those with caring responsibilities, enabling them to work part time or flexibly.
7.	<p>Development and adoption of technological solutions to support older people.</p> <ul style="list-style-type: none"> • Opportunities for independent living with the support of assistive technology remains under-utilised and needs to be explored and developed further. • Suffolk is amongst the nine lowest local authority areas for internet speed and coverage. 	<ul style="list-style-type: none"> • West Suffolk Alliance • Ipswich and East Suffolk Alliance • Suffolk County Council • District and borough councils 	<ul style="list-style-type: none"> • Developing and adopting the use of technological and digital solutions across all Suffolk Alliances. • Continued investment into Suffolk's internet coverage especially in rural areas.

	<ul style="list-style-type: none"> Older residents with poor internet infrastructure are at risk of becoming progressively disadvantaged 		
8.	<p>The establishment of Suffolk as an Age Friendly County</p> <ul style="list-style-type: none"> Given the multifactorial nature of the issues highlighted in this needs assessment, a system-wide approach to healthy ageing is required. Political backing, strong leadership, clear strategy and governance are crucial to ensure the environment we live in supports healthy ageing. 	<ul style="list-style-type: none"> All CCGs Suffolk County Council (including Public Health, Adult and Community Services, Planning) District and Borough councils Ipswich & East Suffolk Alliance West Suffolk Alliance VCSE partners 	<ul style="list-style-type: none"> Continued engagement and involvement of older people in Suffolk Using the WHO Age Friendly Cities (AFC) approach to facilitate initiatives to make Suffolk an Age Friendly County. Implementing recommendations from relevant JSNA reports (e.g. the recently published Suffolk Housing Needs Assessment) will help address some of the domains in the AFC framework. Applying the AFC evaluation tool in local areas (e.g. districts, boroughs, or localities). This can be used to undertake baseline assessments to identify strengths and areas for improvement as well as to plan change and monitor progress in implementing AFC initiatives.
9.	<p>A more coordinated response to dementia and the development of more dementia friendly communities.</p> <ul style="list-style-type: none"> A marked increase in the prevalence of dementia is anticipated in Suffolk. Work to make the county more dementia friendly is increasing but is currently fragmented. 	<ul style="list-style-type: none"> All CCGs Suffolk County Council (including Public Health, Adult and Community Services, Planning) District and Borough councils Ipswich & East Suffolk Alliance West Suffolk Alliance VCSE partners 	<ul style="list-style-type: none"> Implementing recommendations from the Suffolk Dementia Needs Assessment. Increasing dementia awareness across Suffolk for example by: <ul style="list-style-type: none"> encouraging all public-sector employers to consider adopting dementia awareness training as part of staff induction programmes. implementing “dementia-friendly” accreditation schemes across all public-sector organisations in Suffolk.

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Glossary

GLOSSARY	Description
AFC	“An age-friendly city (AFC) encourages active ageing by optimizing opportunities for health, participation and security in order to enhance quality of life as people age.”
BME	Black and Minority Ethnic Groups
CCG	Clinical Commissioning Group – the new local organisations, led by local GPs, which are responsible for planning and designing local health services in England.
CQC	CQC reviews cover all aspects of care including: treating people with dignity and a safe environment
DAA	The Dementia Action Alliance is a movement with one simple aim: to bring about a society-wide response to dementia
Dementia diagnosis rate	The number of people in a given population (for example, those who are registered with a specific GP practice) who have been diagnosed with dementia
DFC	Dementia Friendly Communities This is a programme run by the Alzheimer’s Society which focuses on improving inclusion and quality of life for people with dementia.
Frailty	Frailty is a common clinical syndrome in older adults that carries an increased risk of poor health outcomes including falls, incident disability, hospitalization, and mortality
Health inequalities	Health inequalities are preventable and unjust differences in health status experienced by certain population groups.
HNA	A health needs assessment looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning (buying) of health, well-being and social care services within a local authority area.
ICD-10	International Classification of Diseases – the standard diagnostic tool used worldwide.
ICS	Integrated Care System- CCG geographies are part Sustainability Transformation Partnership (STP))
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LSOA	Lower Super Output Area: this is an area of geography containing between 1000 and 1500 residents
LTC	Long Term Condition
NICE	National Institute for Health and Care Excellence
ONS	Office for National Statistics
Prevalence	A measure of the number (or proportion of a population) of people living with a condition
QOF	Quality and Outcomes Framework - a voluntary annual reward and incentive programme for all GP surgeries, detailing practice achievement results
STP	Sustainability Transformation Partnership- When certain CCG geographies are part proposals to improve health and care in the areas they serve.

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APPENDIX: Evidence Review Tables 1-6

Table 1: General healthy ageing programmes

Literature/ Project/ Research	Background	Findings
<p>Growing older in the UK-BGS society ³⁶</p>	<p>Taking a Life Course Approach towards growing older as evidence shows:</p> <ul style="list-style-type: none"> • Disadvantaged mothers are more likely to have babies with low birth weight • Adverse Childhood Events (ACE's) increase the risk of premature mortality in later life • Children from disadvantaged areas, living in poverty are more likely to experience ACE's • Children living in cold homes are more than twice as likely to develop a variety of cardiovascular and respiratory illnesses • Being unemployed increases the risk of mortality, even for those in higher socio-economic positions • Access to well-maintained green space impacts positively on both mental and physical health • Social isolation is a key driver for poor mental and physical health in later life. • BME communities are likely to have higher rates of poverty, poorer housing/education levels, • BME groups are projected to experience a seven-fold rise in the prevalence of dementia as the population ages, in comparison to a two-fold rise in the rest of the population 	<p>Proposals for action:</p> <ul style="list-style-type: none"> • Early intervention and prevention is recommended, rather than reactive action once ACE's have already been identified • Creating accessible, good quality and well-paid employment will promote healthy living standards, and good work-life balance. • Reducing social isolation in later life and increasing mental stimulation through improved housing conditions, age friendly environments, services and communities, improved living standards, and better access to lifelong learning opportunities • how the delivery, structure and integration of our services should be developed to meet the needs of an ageing population with multi morbidities. • 'Triple integration'; integration of health and social care, primary and specialist care, and physical and mental health care • Substance misuse in older people shows significant increase in rates of licit and illicit drug use and misuse, and rises in alcohol-related hospital admissions and mortality, amongst older people <p>Ageism</p> <ul style="list-style-type: none"> • A recent education-based intervention conducted during a nursing undergraduate module in Spain, focused on the importance of person-centred care and discussion of age-based stereotypes <p>Supporting Carers:</p> <ul style="list-style-type: none"> • Electronic patient records are more timely and promotes integration. • Providing patients with access to their own medical record can allow them to share information with carers as needed, and carers' lives • Carers Passports in hospitals are schemes being developed to identify carers. During a pilot in Manchester, 59% of staff felt improved communication. • Tech enabled care solutions - Carers UK has developed a care coordination app, creates care circles, assigning tasks and synchs with diaries,

<p>Is late-life dependency increasing or not? A comparison of the Cognitive Function and Ageing Studies (CFAS)²⁵</p>	<p>This high-quality paper explored the proportions of dependency states that have changed between generational cohorts of older people, by estimating years lived in different dependency states at age 65 years in 1991 and 2011, and new projections of future demand for care.</p>	<p>Result showed that between 1991 and 2011,</p> <ul style="list-style-type: none"> • there were significant increases in years lived from age 65 years with low dependency (1.7 years [95% CI 1.0–2.4] for men and 2.4 years [1.8–3.1] for women) • increases with high dependency (0.9 years [0.2–1.7] for men and 1.3 years [0.5–2.1] for women). • There were substantial reductions in the proportions with medium and high dependency who lived in care homes • although, if these dependency and care home proportions remain constant in the future, further population ageing will require an extra 71,215 care home places by 2025.
<p>Healthy and active ageing, The Federal Centre for Health Education⁸⁴</p>	<p>This report provides a summary of programmes and interventions that are currently or have been previously applied in the EU and member states to help the ageing population.</p>	<p>Some notable UK projects include:</p> <ul style="list-style-type: none"> • <u>Partnerships for Older People Projects (POPPs) 2005</u> 29 local authority-led partnerships including were funded by the DH to deliver and evaluate local, innovative schemes for older. From 2006-2008, ~100K received service in POPP programme. Estimated that for every £1 spent on POPP, an average of £0.73 will be saved on the per month cost of emergency hospital bed-days. • <u>New Dynamics of Ageing Programme-</u> 8 multidisciplinary research initiatives to improve quality of life of older people-collaboration between five UK Research Councils. High quality findings are ongoing. • <u>Retired and senior volunteer programme (RSVP)-</u> Enabling people aged over 50 to take a lead role in both setting up and participating in volunteering activities
<p>Healthier Ageing, BMJ, 2012,⁸⁵</p>	<p>Healthier ageing is achievable through modifying some lifestyle factors—such as stopping smoking, being more physically active, and eating a balanced diet</p>	<ul style="list-style-type: none"> • Balancing energy intake and expenditure is important for maintaining healthy weight • Preventing chronic diseases may promote healthier ageing through better physical and mental health
<p>World Health Organisation, 2012, European Commission⁸⁴</p>	<p>5 priority interventions for WHO-EU have been identified to support healthy ageing.</p>	<ol style="list-style-type: none"> 1. Prevention of falls- a combination of raising awareness of risk factors, exercise programmes, physical activity and balance training works well. Specialised interventions such as wearing hip protectors 2. Promotion on physical activity-Age related muscle loss affects 40% or men and 50% of women. aged 70-79. An effective redesign the urban environment

		<ol style="list-style-type: none"> 3. Flu Vaccination and prevention-best practice is vaccination annually before the flu season begins. 4. Informal care giving-home care, self-care-without public support caring for someone can lead to reduced workforce participation, higher risk of poverty, can lead to mental health problems, and social isolation. 5. Capacity building amongst the older workforce-Progress in this area has been especially slow, in resolving these insufficiencies. Sound evidence supports to access problems, and shortcomings in the quality of care.
<p>European Commission's- Innovation Partnership for healthy and active ageing (EIP AHA)¹</p>	<p>A pilot project by the European Commission to initiate innovation. It aims to promote healthy and active ageing, with the aim to increase healthy lifespan of EU citizens by the year 2020.</p>	<p>There are is a large repository of innovative practices around ageing. A few of the UK based ones are below, however evaluations are lacking due to the high budget and ongoing nature of the projects:</p> <ul style="list-style-type: none"> • Refer to Pharmacy- East Lancashire Hospitals Trust-An electronic tool, allows bedside referral of patients to their community Evaluation tools are being developed currently- 1777 electronic referrals to community pharmacy in 7 months. Costs around £10K + additional £500 per month • Cities in Balance- Stockport Council-Allows seniors to participate fully in community life, securing social, financial and digital inclusion; business and employment opportunities- - budget €1M - €5M • Living it up-Scotland-online self-management service, for 50yrs and over, uses technology to manage their health and wellbeing, prevention and early initiatives, Cost-€1M - €5M • Altogether Better-National NHS network organisation aims to deliver models on the basis of coproduction. Has developed Health Champions Evaluation of the project has proved effective in improving health outcomes • Electronic Frailty Index (eFI)- Uses Routine GP data to develop integrated care for those with frailty. Uses a frailty score to identify older people with mild, moderate, and severe frailty. Studies on effectiveness have been mixed, more evaluation is needed. • Ageing Well in Wales-Five aims: age-friendly communities, dementia-supportive communities, reduce number of falls, loneliness and isolation, learning and employment opportunities.

		<ul style="list-style-type: none"> • Aiding SuStainable Independent Senior Travellers to Navigate Towns (ASSISTANT)-Online means of planning a trip, guidance on making multistep journeys, ongoing, no evaluation. • MARIO: Managing active and healthy aging with use of caring service robots- the challenges of loneliness, isolation and dementia in older persons through inventions delivered by service robots, evaluation after project has ended. Budget- €1M - €5M
Birmingham Healthy Ageing in the 21st century-Policy Commission statement 83	University of Birmingham in 2011 released a commissioning statement on what healthy ageing should comprise of, focusing on Birmingham demographics.	Main findings: <ul style="list-style-type: none"> • Lack of knowledge about different cultural understandings of ageing may mean we fail to plan appropriately for healthy ageing • The ability of individuals to have control over, and independence in, their lives is a key contributor to healthy ageing • Policy makers need to design policies that harness people's instinctive behaviours to work towards, rather than against, healthy ageing • Older people views need to be heard about environment and local community in order to feel empowered to produce a difference.
Development of a Healthy Ageing Score in the Population-Based Rotterdam Study, Evaluating Age And Sex differences, 2017 ⁷⁹	The aim of this Design Prospective population-based cohort study was to develop a healthy aging score (HAS), to assess age and sex differences and to evaluate the association of the HAS with survival	<ul style="list-style-type: none"> • Levels of HAS were lower in women compared with men, in all age categories. • The HAS declined with increasing age for both sexes, albeit slightly steeper in women. • The HAS was strongly associated with mortality in both sexes.
Predictors of healthy ageing: public health policy targets, 2016 ⁸⁶	<p>Healthy ageing is assessed based on indicators of self-assessed health, functional capabilities and life meaningfulness</p> <p>The logistic regression models are used to assess the impact of the healthy lifestyle index, psycho-social index and socio-economic status on the probability of healthy ageing</p>	<ul style="list-style-type: none"> • The lifestyle index covering vigorous and moderate physical activity, consumption of vegetables and fruits, regular consumption of meals and adequate consumption of liquids is positively related to healthy ageing • The psychosocial index covering employment, outdoor social participation, indoor activities and life satisfaction is also found to be significantly related to health increasing the likelihood of healthy ageing with each point of the index score. • Stimulation physical activity and adequate nutrition are crucial for healthy ageing. The psychosocial elements related to social participation, engagement, networking and life satisfaction are also found to be health beneficial

The Role of the Arts and Culture in Social Care	<ul style="list-style-type: none"> The All-Party Parliamentary Group on Arts, Health and Wellbeing (APPGAHW) has undertaken a major Inquiry into the role of the arts in health and wellbeing, with which the Social Care Institute for Excellence (SCIE) has been involved. 	<ul style="list-style-type: none"> The arts can help keep us well, aid our recovery and support longer lives better lived. The arts can help meet major challenges facing social care: ageing, long-term conditions, loneliness and mental health. The arts can help save money in social care.
Promoting Healthy Aging of Individuals With Developmental Disabilities, 2017 ⁸⁷	<ul style="list-style-type: none"> Qualitative case study examined an innovative community outreach nursing program designed to promote healthy aging for more than 250 individuals with intellectual or developmental disabilities living in the community. Methods: 10 in-depth interviews, one focus group 	<ul style="list-style-type: none"> daily work of community outreach nurses included person centred health education, advocacy for the safe return home support for staff to understand that health issues can lead to behaviour changes, and enabling social participation.
Promoting healthy ageing: Development of the Healthy Ageing Quiz(HAQ), 2013 ⁸⁸	<ul style="list-style-type: none"> Phase 1 (focus groups with 33 older adults, literature review and discussion with an advisory panel) informed the development of a draft HAQ. Phase 2 involved assessing the quiz's psychometric properties and collecting respondent feedback 	<ul style="list-style-type: none"> The quiz showed good psychometric properties and was acceptable to respondents. It allows older adults and people approaching old age to evaluate their current lifestyle to maximise their chances of ageing well
Association of an Index of Healthy Aging With Incident Cardiovascular Disease and Mortality in a Community-Based Sample of Older Adults, 2016 ⁸⁹	<p>The healthy aging index (HAI) was developed as a marker of health in multiple systems that can identify individuals who age most successfully</p> <p>Calculated a HAI in 934 Framingham Offspring Study participants aged 60 or older at baseline</p>	<ul style="list-style-type: none"> In models adjusted for age, sex, and behavioural risk factors, The HAI was associated with mortality (hazard ratio [HR] per unit of HAI 1.24, 95% confidence interval [CI] 1.13-1.36) The HAI was associated with CVD (HR 1.27, 95% CI 1.13-1.42),
Cognitive Decline and Hearing Health Care for Older Adults, 2015 ⁹⁰	<p>There is an important connection between auditory and cognitive aging and the high prevalence of both hearing and cognitive impairments in the oldest older adults</p>	<ul style="list-style-type: none"> Incorporating cognitive factors into audiologic prevention, assessment, and intervention, hearing health care can contribute to better hearing and communication as well as to healthy aging Health care services could be improved by considering how both the ear and the brain change over the life span

<p>Healthy ageing requires a triple strategy, 2016 ⁹¹</p>	<p>To achieve healthy ageing, we need a triple-edged strategy:</p>	<ol style="list-style-type: none"> 1. Promotion of healthy lifestyle at the population level to keep body weight in check, and prevent atherosclerosis and hypertension in the first place: moderate and regular physical exercises, wise and adequate diet, no smoking and low/moderate alcohol consumption, 2. Identification and efficient control/treatment of early and midlife risk factors, especially hypertension, hypercholesterolaemia, smoking and obesity, to ensure that people have good functional capacity when they enter old age 3. Good coordination of services to treat diseases and prevent frailty and disability of older people, also taking into account their special individual and environmental features.
<p>Failing to Focus on Healthy Aging: A Frailty of Our Discipline, 2015 ⁹²</p>	<p>By providing leadership to promote successful aging, the quality of life of older adults across the spectrum can be improved and transitions to frailty reduced.</p>	<p>Several community-based programs have been successful in promoting successful aging. These are potentially highly scalable and could have a substantial effect on the aging population, but their essential components need to be better understood</p>
<p>Time Spent Frail in Old age doubles ⁹³</p>	<p>The amount of time spent needing daily care in late life has doubled</p>	<p>A Newcastle University study found men spent 2.4 years on average needing regular care and women three years. This includes everything from help with washing and dressing each day to round-the-clock care.</p> <p>This includes everything from help with washing and dressing each day to round-the-clock care.</p> <p>Researchers said it suggested there needed to be a sharp increase in the number of care home places to cope</p>

Table 2: Lifestyle

Literature/ Project/ Research	Background	Findings
<p>Heathy Ageing Evidence Review, Age UK ⁴³</p>	<p>Age UK in 2010 conducted an Evidence Review on best practice regarding Healthy Ageing which highlighted projects regarding healthy ageing.</p>	<ul style="list-style-type: none"> • <u>Fit as a Fiddle</u>- 2007-2012 nationwide programme to support people aged over 50 with physical activity, healthy eating and mental well-being through educational and training programmes. Supported 375,392 older people, Evaluation has shown, 'impact on levels of physical activity, healthy eating, and mental wellbeing measured on numerical scales' however few recorded instances of negative outcomes, such as injury or illness. • <u>Ageing Well</u>- (2007) This programme in Scotland was run by older people. Activities include: 20+ seated exercise sessions; five walking programmes. Has targeted 50K people. The Evaluation suggests half people who have taken part have taken steps to improve wellbeing, PA, eating. Qualitative data has shown improvements in information exchange and network/capacity building, however some mention that the programme should have been promoted more for wider roll out.
<p>Alcohol and healthy ageing: a challenge for alcohol policy, 2017 ⁹⁴</p>	<p>This study consisted of qualitative semi-structured interviews conducted with a self-selecting sample of retired people.</p>	<p>From the interviews, the following themes emerged:</p> <ul style="list-style-type: none"> • the use of imposed routines to limit alcohol use and decreasing alcohol intake as participants aged. • Disrupted routines, particularly those associated with bereavement, social isolation and loneliness or the burden of caring responsibilities can increase risk of harmful alcohol consumption • vulnerability to harmful drinking practices brought sudden change of routine in those ageing.
<p>Socioeconomic determinants of risk of harmful alcohol drinking among people aged 50 or over in England, 2015¹⁶</p>	<p>Iparraguire et al, examined the socioeconomic determinants of risk of harmful alcohol drinking and of the transitions between risk categories over time among people age 50 or over responding to the English Longitudinal Survey of Ageing (ELSA).</p>	<p><u>Risks to men:</u> is a non-linear association between age and risk for men (falling with age), in their mid-60s. separated or divorced men show a greater risk of harmful drinking. being healthily, being younger and having a higher income increase the probability of becoming a higher risk alcohol drinker.</p> <p><u>Risks to women:</u></p> <ul style="list-style-type: none"> • Retirement and income were found to be positively associated with a higher risk for women but not for men.

		<ul style="list-style-type: none"> • Women with caring responsibilities were at lower risk of their drinking increasing. • In women, being younger and having a higher income at baseline was associated with increased probability of becoming a higher risk alcohol drinker over time
Healthier Ageing, BMJ, 2012, ⁸⁵	This is a review that explored the healthy behaviours needed to be adopted for maintaining physical and mental independence.	<ul style="list-style-type: none"> • Healthier ageing is achievable through modifying some lifestyle factors—such as stopping smoking, being more physically active, and eating a balanced diet. • Balancing energy intake and expenditure is important for maintaining healthy weight. • Preventing chronic diseases may promote healthier ageing through better physical and mental health.
Lifestyle predictors of healthy ageing in men, 2013 ⁹⁵	This paper reviews the evidence behind gender differences contributing to different healthy ageing behaviours and also how these behaviours might affect health outcomes.	<p>This review shows:</p> <ul style="list-style-type: none"> • men with healthy lifestyles survive longer, • good health and disability is postponed and compressed into fewer years at the end of life. • Physical activity and smoking in midlife and late adulthood impact and predict healthy ageing in men.
Measuring active and healthy ageing in Europe, 2017 ⁹⁶	<p>The active and healthy ageing measure has a specific focus on the current generation of older people and by using the latest data from multiple surveys for 28 EU countries.</p> <p>Active Ageing Index ('AAI') captures how countries differ with respect to capacity and enabling environments for active and healthy ageing.</p>	<ul style="list-style-type: none"> • Sweden comes at the top of the country ranking, followed closely by Denmark, the United Kingdom, Finland, the Netherlands and Ireland • Women fare worse than men in most countries, identifying a need for an emphasis on reducing gender disparity in experiences of active and healthy ageing.
Dental caries and periodontal diseases in the ageing population: call to action to protect and enhance oral health and well-being as an essential component of healthy ageing, 2017 ⁹⁷	<p>Critical review of the scientific evidence and develop specific recommendations to:</p> <p>(i) prevent tooth loss and retain oral function through prevention and treatment later in life</p> <p>(ii) increase awareness of the health benefits of oral health as an essential component of healthy ageing.</p>	<ul style="list-style-type: none"> • Oral health and functional tooth retention later in life provides benefits both in terms of oral and general quality of life and in terms of preventing physical decline and dependency by fostering a healthy diet • health policy should remove barriers to oral health care for vulnerable elders

<p>A life-course approach to healthy ageing: maintaining physical capability, 2014⁹⁸</p>	<p>This article summarises the influences on physical capability in terms of socioeconomic position, lifestyle, underlying physiology and genetic and the idea that social and biological factors from early life onwards affect later health</p>	<ul style="list-style-type: none"> • The review showed that tests of grip strength, walking speed, chair rises and standing balance, which aimed to capture the capacity to undertake the physical tasks of daily living. • There is high quality evidence that higher scores on these measures are associated with lower rates of mortality • There is more limited evidence of lower risk of morbidity, and of age-related patterns of change
<p>What do targeting positive views on ageing add to a physical activity intervention in older adults? Results from a randomised controlled trial, 2014⁹⁹</p>	<ul style="list-style-type: none"> • Randomised controlled trial with three groups aged 65 +: Intervention for physical activity with a 'views-on-ageing'-component (intervention) • active control intervention for volunteering 	<ul style="list-style-type: none"> • 'views-on-ageing'-component within a physical activity intervention affects change in physical activity by changing people's views on ageing. • Views on ageing are a promising intervention technique to be incorporated into future physical activity interventions for older adults
<p>Healthy Ageing and the role of Nutrition and Lifestyle British Nutrition Foundation,</p>		<ul style="list-style-type: none"> • Skin changes (less vitamin D produced) • Changes in taste perception (by age 74-85 the number of taste buds falls by 65% and sensitivity to salty and bitter tastes decrease) • Changes in sense of smell can reduce pleasure of eating • Eyesight & arthritis may make food preparation difficult • Psychosocial factors may also exert a substantial effect on food choice and intake, and hence nutritional status • Bone health is maintained and maximised by a healthy lifestyle and diet.
<p>Older People in Wales- Compendium, 2013¹⁰⁰</p>	<p>An overview of innovative practice in Wales that supports healthy ageing</p>	<ul style="list-style-type: none"> • <u>Free swimming</u> is available in every county for people aged 60 and over • <u>National Exercise Referral Scheme. (NERS)</u> for clients who have fallen, had a stroke or heart attack, or who have or are at risk of a chronic condition which can be improved through exercise • <u>Education Programmes for Patients</u> are run across Wales. The programme provides self-management health and well being courses and workshops for people living with, or caring for someone else with, a chronic condition • <u>Promote a systematic approach</u> to identifying individuals at higher risk of falls • <u>Engaging older people</u> as champions for digital inclusion

<p>Nutritional interventions for optimizing healthy body composition in older adults in the community: an umbrella review of systematic reviews, 2016 ¹⁰¹</p>	<p>The aim of this study was to measure the effectiveness of nutritional interventions for optimising healthy body composition in older adults living in the community and to explore their qualitative perceptions. Studies on weight loss showed that diet in combination with exercise and nutrition counselling on its own can lead to reduced weight in older people.</p>	<ul style="list-style-type: none"> • Studies on weight loss showed that diet in combination with exercise, diet in combination with exercise and nutrition counselling, and nutrition counselling on its own all can lead to reduced weight in older people. • Multiple interventions are more effective than single interventions
<p>The Symbiotic Relationship Between Oral Health, Nutrition, and Aging, 2016 ¹⁰²</p>		<ul style="list-style-type: none"> • As with a good diet there is very good evidence that a healthy mouth also vastly contributes to healthy ageing. • Additionally, food security is an important factor in a healthy old age; food security consists of an older adult being confident of being able to purchase food, and prepare meals independently.
<p>Evaluation of the Suffolk Fit Villages Programme ¹⁰³</p>	<p>Fit Villages is delivered by Suffolk Sport and is funded through Suffolk County Council's Most Active County Partnership Programme, Sport England's Community Sport Activation Funding (CSAF) and Suffolk Sport for the financial years 2014-15, 2015-16 and 2016-17. The Fit Villages programme was specifically designed to fill a gap in provision of physical activity opportunities at local level in rural areas. There is evidence from recent research that residents of rural areas in England are less physically active than their urban counterparts.</p>	<p>Evaluation showed, number of minutes spent in weekly vigorous PA increased from 15.9 minutes at baseline, to 52 mins at 3 months follow up, $p < 0.001$. Weekly walking baseline (71.5mins) to 3 months follow up (90.3 mins) $p < 0.001$. Increases in social interaction and isolation were all seen with statistically significant results $p < 0.001$</p>
<p>Care About Physical Activity initiative, Scotland (CAPA) ¹⁰⁴</p>	<p>This resource offers support for everyone in a care home to get involved and become physically active in different ways, not just through formal exercise sessions. This will help national and local organisations to promote physical activity in care homes. There are both links to Physical Activity tools and Self-Assessment tools.</p>	<p>An early evaluation of the impact of the project has shown:</p> <ul style="list-style-type: none"> • Care home managers and staff were generally very positive about all aspects of the resource pack. of value in terms of improving health and wellbeing for residents and also to their service. • Half of homes have either used or started to use the resource in care planning for residents • Many thought the resource had made staff more aware of the need to encourage physical activity; • Focus groups were held with care homes that had indicated that they had undertaken some activities as a result of the project.

		<ul style="list-style-type: none"> • SCC is currently working with this project lead to develop a physical activity self-assessment toolkit for care settings in Suffolk.
Identifying what works for local physical inactivity interventions, Public Health England <small>105</small>	An example of a project aimed at older people is, Project ACE. Location: South West Setting: LA leisure facility	Evaluation of the ACE programme show that it has a considerable impact on the health and social outcomes of the participants. <ul style="list-style-type: none"> • 55% of the intervention group reported an increase in vitality compared to 22% of the control group • Social wellbeing, 68% reported an increase, 59% reported an increase in life satisfaction, 50% of participants improved their functional ability
Suffolk Physical Activity Initiatives	Local Projects in Suffolk aimed at Active Ageing	<ol style="list-style-type: none"> 1. <u>ActivIpswich</u> ActivLives and IBC partnership focusing on 45+ who are not active. 2. <u>GoodGym</u>-Although not directly engaging older people in activity a novel way of using activity (i.e. running) as a way of tackling isolation in older people. GoodGym Ipswich launched (4th Sept). 3. <u>Sporting Memories</u>- Sporting Memories tackles healthy ageing through dementia, depression, loneliness and inactivity through Sporting Memories. At least 5 Sporting Memories Groups are being established in Suffolk over the next 12 months.

Table 3: Community, social isolation and loneliness

Literature/ Project/ Research	Background	Findings
<p>Healthy and active ageing, The Federal Centre for Health Education,⁸⁴</p>	<p>Participation/social inclusion, including engagement in voluntary work and mental health is essential for continuing healthy ageing.</p>	<ul style="list-style-type: none"> • <u>Brighter Futures</u> was a pilot peer mentoring service for isolated older people run by the Mental Health Foundation in Scotland as well as other partners. Evaluation identified improvements in perceived social isolation were indicated for 74% participants after 9 months, numerous positive qualitative data • <u>Internet community 50 plus net</u> is a virtual meeting place for those over 50 in Netherlands aiming to increase social participation with more than 33.000 active members. Evaluation has shown, participants feel they have gained new contacts, and have received support and advice from others.
<p>Interventions targeting social isolation in older people: a systematic review (2011) Dickens et al¹⁰⁶</p>	<p>Systematic Review Relevant electronic databases, for randomised controlled trials and quasi-experimental studies. Studies were included if they related to older people, if the intervention aimed to alleviate social isolation and loneliness, if intervention participants were compared against inactive controls and, if treatment effects were reported.</p>	<p>32 studies were located and included in the review. It appeared that common characteristics of effective interventions were those:</p> <ul style="list-style-type: none"> • developed within the context of a theoretical basis • offering social activity and/or support within a group format • in which older people are active participants <p>Future interventions incorporating all of these characteristics may therefore be more successful in targeting social isolation in older people.</p>
<p>Promising approaches to reducing loneliness and isolation in later life (Age UK, 2015)²¹</p>	<p>As in previous studies, this project identified a lack of high quality evidence to demonstrate the impact of different specific interventions on loneliness.</p> <p>Part of the Campaign to End Loneliness https://campaigntoendloneliness.org/guidance/</p>	<p>The approaches the experts most often identified as effective were those designed to address three key challenges:</p> <ol style="list-style-type: none"> 1. Reaching lonely individuals 2. Understanding the nature of an individual's loneliness and developing a personalised response 3. Supporting lonely individuals to access appropriate services <p>These approaches were focussed on the individual, and were the first steps taken as part of the work to reduce an individual's loneliness, coming before and providing a way into the more commonly recognised loneliness interventions, such as social groups and befriending schemes (as described in most systematic reviews)</p>

		<p>Experts were also excited about approaches which aimed to create the right environment for loneliness to be reduced. These approaches were characterised as ‘structural enablers’.</p> <p>These included:</p> <ul style="list-style-type: none"> • Neighbourhood approaches – working within the small localities with which individuals identify. • Asset based community development (ABCD) – working with existing resources and capacities in the area to build something with the community. • Volunteering – with volunteers creating a ‘virtuous circle of Volunteering’ whereby service users become volunteers. • Positive ageing – approaches including Age Friendly Cities, Dementia Friendly Communities, etc
<p>Centre for Ageing Better Evidence Briefing: The benefits of making a contribution to your community in later life (Jones et al, 2015)¹⁰⁷</p>	<p>Systematic review of the literature on what volunteering as an older person can bring to that older person</p>	<p>There is good evidence that older people who make voluntary contributions report:</p> <ul style="list-style-type: none"> • an increase in the quantity and quality of their social connections • an enhanced sense of purpose and self-esteem • improved life satisfaction, happiness and wellbeing <p>Where people in later life feel valued and appreciated in their formal volunteering roles, there is evidence that this contributes to reduced depression.</p> <p>People with higher levels of health, wealth, social connections and wellbeing are more likely to volunteer in the first place, and the evidence suggests that these characteristics are <u>both causes and consequences</u> of contributing.</p> <p>There is some evidence that the benefits are greater for older people with fewer personal and social resources, lower educational attainment and fair health. They should be prepared to meet the additional costs of supporting these people to participate where necessary</p>
<p>Good days & bad days: Stories of ageing in the community, The Young Foundation, 2011¹⁰⁸</p>	<p>An ethnography as a series of case studies of 16 older people in South London and rural communities in the South West of England, with whom the researchers spent 10 days each.</p>	<p>Common themes emerging from the ethnography:</p> <ul style="list-style-type: none"> • A network of care <ul style="list-style-type: none"> ○ Many people, organisations and services were involved in caring and supporting older people, varying from statutory health and social care providers to the informal support offered by friends, neighbours and the wider community.

	<p>(Ethnography is an approach to understand people within their own social and cultural contexts)</p>	<p>Often the most important carer was the (often also elderly and frail) spouse of the older person.</p> <ul style="list-style-type: none"> • Transition points and isolation <ul style="list-style-type: none"> ○ Many of the people spoken with had experienced difficult or traumatic transitions <ul style="list-style-type: none"> ▪ Bereavement ▪ serious illness ▪ hospital admission and recovery period ▪ loss of a driving license ▪ becoming housebound ▪ moving house ▪ becoming a carer. <p>Commissioners, clinicians and providers should explore how they can:</p> <ul style="list-style-type: none"> • Understand and better exploit the network around the older person • Map who provides support from the community before crises happen, so that these support networks are not lost at key transition points such as bereavement, a significant spell in hospital or when an older person stops driving • Consider asking older people about their social networks to record alongside more traditional clinical records and diagnoses • Look at how they can develop these community networks where they are weaker • Engage differently with the formal voluntary sector by asking openly what it can do well, rather than coming with a pre-prepared requirement
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Table 4: Environment and workforce

Literature/ Project/ Research	Background	Findings
<p>How to promote Ageing Well in Europe, European Union Committee of the Regions, 2009 ¹⁰⁹</p>	<p>The paper focuses on several different streams of ageing with some focus on workforce in Europe.</p>	<p>This includes project aims to capitalise innovative approaches towards demographic change through the exchange of good practices on older workers, training of older workers, or managing age diversity.</p> <ol style="list-style-type: none"> 1. Increasing Ageing Profile of the working population. Working with European partners, the project aims of increase the value of working for those over 50. Those looking to retrain or change in skills therefore providing flexibility for an ageing population. <ul style="list-style-type: none"> • Focuses on how to adapt the workplace for older people, short term or remote contracts for older people and ICT training for older people. • Aims to allow seniors to be aware of their skills and competencies and transfer to younger generations, therefore promoting intergenerational learning.
<p>Progress towards Healthy Ageing in Europe: to promote active healthy lifestyles in 45-68 year olds through workplace, rather than traditional</p>	<p>Two-year European funded project led by Suffolk County Council Public Health and involving five European Union (EU) member nations.</p> <p>Qualitative research applying an online Health Manager tool and focus group discussions. Transnational work to learn from other EU countries about approaches to promote healthy active ageing.</p>	<ul style="list-style-type: none"> • Its objective was to develop innovative approaches to improving the health and lifestyle choices of seniors, from 45-68 age range, through interventions delivered in their workplace. • The findings have added momentum to local workplace health initiatives by providing a focus for the needs of the older workforce • Learning from the Project has also informed development of the Suffolk Workplace Challenge.

<p>health-related settings¹¹⁰</p>		
<p>Fuller Working Lives- A partnership Approach- Department for Work and Pensions, Feb 2017⁶⁹</p>	<p>People in the UK are living longer, and the proportion of older workers in the labour force is increasing</p> <p>A Fuller Working Lives Business Strategy Group was set up by the Department for Work and Pensions (DWP). Members were given the scope to identify and focus on areas they believed required change, reviewing a series of topics to see how they could improve the retention, retraining and recruitment of older workers.</p>	<ol style="list-style-type: none"> 1. Many multinational organisations have adopted initiatives for older people: <ul style="list-style-type: none"> • Mercers UK- reverse mentoring programme • Aviva-mid career reviews for over 50's • Johnson and Johnson- (Health Focus) Flu vaccinations, cholesterol testing, weight watchers, sport, H+W advice- • Jaguar Land Rover- (Making staff feel valued) Piloting a retirement transitions initiative 2. Chelsea and Westminster NHS Trust-staff access to a range of online support and information, up to 5 days paid emergency time off to care for dependents, and a flexible working policy <p>The government is supporting those who need extra help by focusing on:</p> <ul style="list-style-type: none"> • Women – working in partnership to make clear to employers the value that women bring to the workplace. • Carers – aiming to support carers through a new cross-Government Carers Strategy • People with long-term health conditions and disabilities –recently published the 'Improving Lives, the Work Health and Disability Green Paper'. • Black and Minority Ethnic (BME) Groups. <p>Recommendation for businesses:</p> <ul style="list-style-type: none"> • Encourage flexible/agile/dynamic working for carers • Review employee benefits to ensure that they are flexible enough • transfer knowledge between generations/encourage mentoring • Encourage employees to think about multiple part time roles • Enhance the profile of volunteering, utilising industry skills, and apprenticeships

<p>What are the sociodemographic and health determinants for older adults continue to participate in work, 2017³³</p>	<p>Data were collected and evaluated for 1762 older adults aged 65 years and older who were living in the community and were enrolled in a population-based study</p> <p>A multivariate hierarchical logistic regression analysis was performed.</p>	<p>Factors associated with not participating in the workforce were:</p> <ul style="list-style-type: none"> • Age (OR: 1.71, [95% CI: 1.26–2.30], $p < 0.001$), • female gender (OR: 1.70, [95% CI: 1.22–2.37], $p = 0.002$), • poor visual perception (OR: 1.31, [95% CI: 1.00–1.72], $p = 0.046$), using 4 or more medications regularly (OR: 1.41, [95% CI: 1.489–2.247], $p = 0.034$), • having 3 or more comorbidities (OR: 1.44, [95% CI: 1.01–2.04], $p = 0.040$), • handgrip strength <p>Our results highlight that work in later life is influenced by sociodemographic characteristics, intrinsic capacity, and multi morbidity. The suggest that strategies for optimising healthy and active aging may help older people to continue participating in the workforce and contributing toward their communities.</p>
<p>Key areas for health promotion amongst younger older people.¹¹⁰</p>	<p>Employment at transition into retirement</p> <p>There is a solid argument to encourage those to work longer, employment makes people feel valued and belonging to society. Evidence has shown that country-specific, tailor made policies aimed at stimulating part-time employment of older adults may be quite effective in raising the labour force participation of older adults.</p>	<p>A 2006 study-based on 41 case studies from 11 EU countries. How employment rates can be raised and retirement age extended without impairing life quality and compromising work/life balance or cost-efficiency aspects.</p> <p>ASPA-a research project 2010 to activate senior potential found that Age and diversity - management of volunteers is a concept quite unfamiliar to volunteering organisations. Moreover, a clearer analysis of costs and benefits of involving older volunteers seems to be needed</p>
<p>Association Between Purpose in Life and Objective Measures of Physical Function in Older Adults⁷²</p>	<p>Is higher purpose in life associated with lower likelihood of objectively measured declines in physical function?</p>	<p>In a longitudinal cohort study of adults older than 50 years who were adequately functioning at baseline, each 1-SD increase in purpose in life was associated with a 13% decreased risk of developing weak grip strength and 14% decreased risk of developing slow walking speeds 4 years</p> <p>A purpose in life was prospectively associated with a decreased risk of developing weak grip strength and slow walking speed, although the findings were more robust for walking speed than for grip strength. These findings suggest that a sense of purpose in life, a modifiable factor, may play an important role in maintaining physical function among older adults.</p>
<p>Healthy Ageing Technology</p>		

Transformation through Technology (Southend CCG)	Pilot Project where they <ul style="list-style-type: none"> • Implemented + monitored Assistive Technology in homes • Helped retain independence for patients 	2 devices were piloted in the project: <p><u>1. Just Checking</u>- Wireless IR sensors, 24hr web access to monitor activity, very flexible Able to monitor activity</p> <p><u>2. Mind Me Locate</u>- GPS tracker: Tracked through a website useful for those prone to wondering</p>
CARESSES Project, University of Bedfordshire,	Study began in January 2017 and will be completed in January 2020	Built on the premise that cultural competence among nursing staff is associated with better patient outcomes to build: <ul style="list-style-type: none"> • Culture-Aware Robots and Environmental Sensor Systems for Elderly Support • To design and evaluate culturally aware and competent elder care robots that adapt their interactions according to the culture of the person they are assisting
Developing Care for a changing population: patient engagement and health information technology , Nuffield Trust, 2016 ¹¹¹	Assistive technologies help compensate for lost or failing physical skills, and include simple devices like jam-jar openers. Telehealth and telecare interventions, such as an automated text message to remind a patient with early Alzheimer's to take their medication, fulfil a similar role	<ul style="list-style-type: none"> • Although those aged over 65 still use the internet half as much as younger people, among this age group there has been a rapid rate of increase, from only 9% using the internet in 2006 to 42% in 2014 • Through its Technology Enabled Care Services (TECS) programme, the Department of Health encourages health care commissioners to consider investing in a variety of remote services, including wearable monitors, urine and blood analysers, blood pressure monitors, text messaging, movement sensors and alarms. • However, the evidence that these interventions can be cost-effective, acceptable or reduce burden on professionals is not yet clear
The Digital Patient, transforming Primary Care, 2016 ¹¹²	There is an emerging body of evidence suggesting that apps can have a positive impact on diet monitoring; physical activity; adherence to medication and chronic condition management, particularly for multiple sclerosis, Parkinson's disease and cardiovascular disease.	<ul style="list-style-type: none"> • Amongst the older old, over two thirds of people over 75 still never use the internet at all • Whilst others will find decline in their 'mechanical cognition' with age will lead to difficulties navigating systems previously understood. Balancing the benefits of technology for those who can access it with preventing the exclusion of those who cannot will be vital. • Apps that use 'gamification' and established behaviour-change techniques such as prompting goal setting, review and feedback on performance to encourage engagement may prove increasingly

		<p>important in helping to sustain behaviour change. But many apps are inaccurate and the efficacy of the majority of them is unknown</p> <ul style="list-style-type: none"> The use of technology for enabling social contact and participation can be very successful, but many older people need help getting started, and ongoing support. Many websites are poorly designed and are not fully accessible to older users, and it is important that local and national services – increasingly moving to ‘online only’ models – ensure that their website are viewable and navigable to all
<p>What are the likely changes in society and technology which will impact upon the ability of older adults to maintain social network of support now in 2025 and 2040-Future of an ageing population, 2015¹¹³</p>	<p>Technological access will also be defined in some cases by affluence, educational background and by home and local infrastructure such as internet speed. Areas of the UK with the worst internet connection speeds also tend to contain greater than average numbers of over-65s</p>	<ul style="list-style-type: none"> Suffolk is among the bottom nine administrative authorities in England for internet speed and coverage. Older residents in areas with a poor internet infrastructure are at risk of becoming progressively more disadvantaged <p>Source: Ofcom (2013a), Office for National Statistics (2013).</p>
<p>Health Technologies: Are older people interested?, 2016¹¹⁴</p>	<p>Patients with multiple conditions – more likely to be the case with age – and their carers may struggle with navigating emergency situations without all professionals having access to all records</p>	<ul style="list-style-type: none"> For older people, the most immediately beneficial use of technology may be maintaining social links and preventing loneliness. It is important that care homes consider the needs of their residents for wifi access for these purposes It has also been suggested that reliance on machines may undermine self-efficacy, and, by removing the need for Health Visitors or checks by relatives remove a source of personal interaction from the lives of often isolated older people A scheme in London – ‘Coordinate My Care’ – creates a shared health record between patients, carers and statutory health organisations, providing people with life-limiting illnesses an opportunity to create a personalised care and end of life plan, which can be shared electronically with all legitimate providers

Table 5: Dementia and end of life

Literature/ Project/ Research	Background	Findings
<p>DEMCOM- National Evaluation of Dementia Friendly Communities</p>	<p>A project funded by Department of Health Policy Research Programme to undertake a national evaluation of Dementia Friendly Communities. The aim is to understand how different types of DFCs work, what is needed to sustain them and how they help different groups of people living with dementia and carers to live well. The project is funded from January 2017-2019.</p>	<p>An Evaluation tool for age friendly cities study is being developed. (NIHR)- To contribute to ensuring that AFC initiatives are evidence-based and evaluated, which has been piloted in 3 sites and being used in the DEMCOM study. Some preliminary findings show that:</p> <ul style="list-style-type: none"> • Walking surfaces –there needs to be a balance between them being aesthetically pleasing, and suitable for older people • Steps and kerbs -edges need to be clearly marked with contrasting material so that they can be seen • Walking routes -reduce the potential for them to become temporarily blocked (e.g. bins, parked bikes), which may cause a fall risk
<p>Age appropriate services for individuals diagnosed with Young Onset Dementia (YOD)¹¹⁵</p>	<p>Nationally what exists for YPD services:</p> <ul style="list-style-type: none"> • <u>Nottinghamshire</u>: Working Age Dementia Service • <u>Leicestershire</u>: Young Onset Dementia Assessment Service • <u>Cardiff and Vale University Health Board</u>: Younger Onset Dementia Service. • <u>Glasgow and Clyde</u>: Young Onset Dementia Service • <u>Manchester</u>: Young Onset Dementia Service • <u>Cambridgeshire and Peterborough</u>: Young people with Dementia Service 	<p>Age of young onset</p> <ul style="list-style-type: none"> • Likely to still be in employment • Comparatively high levels of physical fitness – not well matched to join more sedentary services designed for older age groups <p>Younger onset often shows types of rarer forms of dementia</p> <ul style="list-style-type: none"> • (frontotemporal dementia [FTD]); • Behavioural variant (bv FTD): reduced abilities to recognise emotion / inability to control impulse • Consequently, higher carer burden <p>Services perceived as most useful</p> <p>How to go forward:</p> <ul style="list-style-type: none"> • Sustainability: Project-based commissioning (currently ad-hoc) • Co-design of services that contribute to creating a care pathway • Service design that is informed by evidence of costs including family-borne costs related to age-appropriate interventions (cost of illness)

<p>Screening Buckinghamshire Residents in Care Homes for Dementia, Chiltern and Aylesbury CCG</p>	<p>A care home screening project was established - cost £50K - delivered by an experienced CPN for 6 months</p> <ul style="list-style-type: none"> • 450 patients were screened in 40 care homes • Conversion rate to a diagnosis was approximately 1/3 • DiADeM Tool – Diagnosing Advanced Dementia 	<p>This protocol aims to support GPs to diagnose dementia for people living with advanced dementia in a care home setting.</p> <p>DiADeM is designed to be used only with those patients living with advanced dementia within a care home setting for whom a trip to memory services is unlikely to be feasible and/or make a difference to ongoing management.</p>
<p>How can planners rise to the dementia challenge?</p> <p>Royal Town Planning Institute¹¹⁶</p>	<p>There is a RTPI virtual learning site for planners which now includes a module on Dementia:</p>	<ol style="list-style-type: none"> 1. Worcestershire County Council have worked with planners from the three South Worcestershire Councils to develop a draft Planning for Health Supplementary Planning Document which contains sections dedicated to ‘age friendly environments and dementia’. 2. As part of Belfast’s successful application to become a World Health Organization age-friendly city, it developed an assessment tool to gauge how accessible the built environment is for older people. It carried out walks with people with dementia living in supported housing to gain their opinions and use their experience of the walking environment in their area. 3. In Bradford, a project led by people with dementia. They have provided feedback on signage and accessibility, advised on a hospital refurbishment 4. Hogeweyk Village, in Weesp in The Netherlands, is recognised as a world leader in the design of the facilities and care for its 152 residents living with dementia
<p>PHE, Changing Risk Behaviours and promoting Cognitive Health in older adults⁸⁶</p>	<p>Developed an evidence-based resource for commissioners and local authorities.</p>	<p>Resource is aimed to give a steer as to what types of interventions should be focused on to help uptake of healthy behaviours amongst older adults.</p>
<p>Dementia Awareness in Minority Ethnic Populations,</p>	<p>The projects aim was to increase recorded prevalence of Dementia on South Asian and travelling communities</p>	<ul style="list-style-type: none"> • Through Health Checks for ~200 people • Generic memory tests started within the community

Cambridgeshire and Peterborough CCG		<ul style="list-style-type: none"> • Dementia Support Worker as the main lead-they continue to deliver sessions for minority ethnic groups. • Dementia and Cultural Awareness Conference Workshop cater to 200+ people. • They bought out a Culture and Dementia Guidance to be distributed.
Coordinating Dementia Support for people with Learning Disabilities, Hertfordshire CCG	<p>A project to look at how to increase the efficiency of Dementia Services for those with LD specifically.</p>	<ul style="list-style-type: none"> • Created a LD pathway • Pathway embedded into nursing training • People with LD who didn't know about DA now do. • Encouraging the use of main stream services rather than separate specialist services • LD champions now in every ward • Embedded in main contract
Creating Age Friendly Cities, 2016,	<p>The concept of an 'age-friendly city' was developed by the (WHO) and the term refers to a city that enables and encourages people to age well according to their needs, desires and capacities</p>	<p>An Evaluation tool for age friendly cities study is being developed. (NIHR)- To contribute to ensuring that AFC initiatives are evidence-based and evaluated.</p> <ul style="list-style-type: none"> • Being used in the DEMCOM study and has been piloted in three sites: • Evaluation tool, together with findings from other sites, has drawn attention to issues relevant to age-friendliness: <ul style="list-style-type: none"> ○ <u>Walking surfaces</u> –balance needed-aesthetically pleasing, and suitable for older people ○ <u>Steps and kerbs</u> -edges need to be clearly marked with contrasting material so that they can be seen ○ <u>Walking routes</u> -reduce blockages (e.g. bins, parked bikes), which may cause a fall risks.
National Institute of Health Research, 2016-2017	<p>In the past year the National Institute for Health Research has funded three research projects into improving end of life care, investing a total of £1,288,475</p> <p>Other end of life care research projects, totalling an investment of £3,935,242, include</p>	<ul style="list-style-type: none"> • The Namaste Care intervention to improve the quality of dying for people with advanced dementia living in care homes: a realist review and feasibility study for a cluster randomised controlled trial • Improve Care: The management of clinical uncertainty in end of life care - a feasibility cluster • CARer-Administration of as-needed sub-cutaneous medication for breakthrough symptoms in home-based dying patients: a UK study • Other end of life care research projects, totalling an investment of £3,935,242. • Supporting Excellence in End of Life Care in Dementia • C-CHANGE: Delivering high quality and cost-effective care across the range of complexity for those with advanced conditions in the last year of life

<p>The Government Response to the Review of Choice in End of Life Care, Department of Health September 2017</p>	<p>This review goes through the progress that has made from the Ambitions of Palliative Care Report from 2015. This is a government response to choices in end of life care.</p>	<p><u>Personalised care for people approaching the end of life</u></p> <ul style="list-style-type: none"> • One of the key aspects is the roll out of shared digital palliative and end of life care records, such as Electronic Palliative Care Coordination Systems (EPaCCS), to the majority of areas by 2018 and all areas by 2020 • To promote choice and personalisation at the end of life, NHS England has led a social media campaign to raise the profile of the Government End of life Care Commitment • NHS England also continued their work with five local areas to consider how personal health budgets could work within end of life care to personalise services and improve choice and control for individuals at the end of life • The Serious Illness Conversations pilot being tested by the New Care Model sites in Airedale and Southend has successfully led to extensive system change across the three pilot sites, including: the development of a screening tool to identify patients; a questionnaire to enable conversations; and an agreed clinical workflow • The National Council for Palliative Care (NCPC) and NHS England produced a patient empowerment film providing advice and guidance for people with advanced diseases and long-term conditions to prepare for consultations with clinicians. <p><u>Measures to improve care quality for all across different settings</u></p> <ul style="list-style-type: none"> • This year, the CQC has completed inspections of all hospital and community health services, and reported on and rated end of life care as a core service • The National End of Life Care Programme Board brings together lead directors from across NHS England to ensure opportunities for joint working and alignment are maximised. • To improve end of life care in hospitals, NHS England and NHS Improvement established an oversight board for the Transforming End of Life Care in Acute Hospitals Programme

		<ul style="list-style-type: none"> • To improve end of life care in care homes and spread lessons from existing Vanguard sites that include care homes, an <i>Enhanced Health in Care Homes framework</i> was published in September 2016. <p><u>Innovation in the delivery of high quality care</u></p> <ul style="list-style-type: none"> • The National End of Life Care Programme Board is developing a collaborative support offer to engage with STP leads. • Over the last year, NHS England worked collaboratively with regional partners to successfully host nine End of Life Care Roadshow events across the country to showcase best practice and promote person centred care and patient empowerment • Working with NCPC, NHS England expanded the Ambitions for Palliative and End of Life Care website to create a Knowledge Hub which brings together end of life care tools and resources in one place. • In February 2017, Public Health England published <i>Cost effective Commissioning of End of Life Care</i> • To support commissioners, NCPC published seven evaluations of different approaches to 24/7 models of care <p><u>National and local leadership to prioritise and improve end of life care</u></p> <ul style="list-style-type: none"> • To support commissioners, NHS England and Public Health England published an individual-level clinical dataset for adult specialist palliative care in December 2016. NHS England also published a definitive set of palliative care currencies in April 2017 to help in quantifying palliative care complexity locally <p><u>The right knowledge and skills to deliver high quality personalised care</u></p> <ul style="list-style-type: none"> • Working with key members of its Medical and Nursing Advisory Groups, Health Education England is strengthening the undergraduate and postgraduate curricula to support patient choice and improve quality in end of life care • Health Education England has produced materials with NHS Employers to promote best practice on employer-led training to demonstrate the benefits to employers to incentivise further investment in end of life care training • NCPC and the Dying Matters group led #KnowAboutMe, a social media campaign to raise public understanding and expectations about record sharing in end of life care during March and April 2017
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Table 6: NICE guidelines

Literature/ Project/ Research	Background	Findings
<p>Excess winter deaths and illness and the health risks associated with cold homes</p> <p>NICE guideline [NG6] March 2015¹¹⁷</p>	<p>This guideline covers reducing the health risks (including preventable deaths) associated with living in a cold home. It aims to improve the health and wellbeing of people vulnerable to the cold. Improving the temperature in homes, by improving energy efficiency, may also help reduce unnecessary fuel consumption</p>	<ol style="list-style-type: none"> 1. Recommendation 1: Develop a strategy 2. Recommendation 2: Ensure there is a single-point-of-contact health and housing referral service for people living in cold homes 3. Recommendation 3: Provide tailored solutions via the single- point -of-contact health and housing referral service for people living in cold homes 4. Recommendation 4: Identify people at risk of ill health from living in a cold home 5. Recommendation 5: Make every contact count by assessing the heating needs of people who use primary health and home care services 6. Recommendation 6: Non-health and social care workers who visit people at home should assess their heating needs 7. Recommendation 7: Discharge vulnerable people from health or social care settings to a warm home 8. Recommendation 8: Train health and social care practitioners to help people whose homes may be too cold 9. Recommendation 9: Train housing professionals and faith and voluntary sector workers to help people whose homes may be too cold for their health and wellbeing 10. Recommendation 10: Train heating engineers, meter installers and those providing building insulation to help vulnerable people at home 11. Recommendation 11: Raise awareness among practitioners and the public about how to keep warm at home 12. Recommendation 12: Ensure buildings meet ventilation and other building and trading standards
<p>Falls in older people: assessing risk and prevention</p>	<p>This guideline covers assessment of fall risk and interventions to prevent falls in in people aged 65 and over. It aims to reduce the risk and incidence of falls and the associated</p>	<ol style="list-style-type: none"> 1. multifactorial risk assessment of older people who present for medical attention because of a fall, or report recurrent falls in the past year 2. multifactorial interventions to prevent falls in older people who live in the community

Clinical guideline [CG161], April 2013⁵¹	distress, pain, injury, loss of confidence, loss of independence and mortality.	<ol style="list-style-type: none"> 3. multifactorial risk assessment of older peoples' risk of falling during a hospital stay 4. multifactorial interventions to prevent falls in inpatients at risk of falling
Home care: delivering personal care and practical support to older people living in their own homes, [NG21] 2015¹¹⁸	This guideline covers the planning and delivery of person-centred care for older people living in their own homes (known as home care or domiciliary care). It aims to promote older people's independence and to ensure safe and consistently high-quality home care services.	<ol style="list-style-type: none"> 1. Ensuring care is person centred 2. Providing information about care and support options 3. Planning and reviewing home care and support 4. Delivering home care 5. Joint working between health and social care 6. Ensuring safety and safeguarding people using home care services 7. Recruiting, training and supporting home care workers
Mental wellbeing in over 65s: occupational therapy and physical activity interventions, [PH16] October 2008¹¹⁹	This guideline covers promoting mental wellbeing in people aged over 65. It focuses on practical support for everyday activities, based on occupational therapy principles and methods. This includes working with older people and their carers to agree what kind of support they need.	Recommendations relating to: <ol style="list-style-type: none"> 1. Occupational therapy interventions 2. Physical activity 3. Walking schemes 4. Training
Older people with social care needs and multiple long-term conditions [NG22], November 2015¹²⁰	This guideline covers planning and delivering social care and support for older people who have multiple long-term conditions. It promotes an integrated and person-centred approach to delivering effective health and social care services	<ol style="list-style-type: none"> 1.1 Identifying and assessing social care needs 1.2 Care planning 1.3 Supporting carers 1.4 Integrating health and social care planning 1.5 Delivering care 1.6 Preventing social isolation 1.7 Training health and social care practitioners
Older people: independence and mental wellbeing NICE guideline [NG32], 2015¹²¹	This guideline covers interventions to maintain and improve the mental wellbeing and independence of people aged 65 or older and how to identify those most at risk of a decline.	<ol style="list-style-type: none"> 1.1 Principles of good practice 1.2 Group-based activities 1.3 One-to-one activities 1.4 Volunteering 1.5 Identifying those most at risk of a decline in their independence and mental wellbeing